

Broken Condoms, Corroded Trust: The politics of HIV prevention in Namibia

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A Thesis

in

The Department

of

Sociology and Anthropology

Presented in Partial Fulfillment of the Requirements
for the Degree of Master of Arts (Social and Cultural Anthropology) at
Concordia University
Montreal, Quebec, Canada

August, 2007

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ISBN: 978-0-494-34767-6

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ISBN: 978-0-494-34767-6

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ABSTRACT

Broken Condoms, Corroded Trust: the politics of HIV prevention in Namibia

Nicole Rigillo

This thesis examines the ways in which conceptions of “safe sex” through condom use differ between the targets, critics and promoters of HIV prevention strategies in urban Namibia. To this end, the author conducted interviews and participant observation among young people, Pentecostal religious leaders, and HIV prevention experts in Windhoek, Namibia’s capital, between August and November 2006. Among these first two groups, the spread of what HIV prevention experts labelled as “rumours” or “myths” about condoms were found to be common. Young people perceived the safety of safe sex to be influenced by the brand and cost of condom used, while Pentecostal religious leaders instead questioned the safety of condoms in general, using scientific data and tapping into media outlets to challenge their promotion as a viable way of ending the HIV epidemic in Namibia. In contrast, HIV prevention experts largely conceived of safe sex as a rational choice made by individuals to either abstain, be faithful or use condoms, conceiving of anti-condom discourses as “rumours” or “myths” that could best be combated with the dissemination of biomedical information. I argue that such an approach does little to halt the spread of anti-condom discourses, since it neglects an acknowledgment of the social and historical factors specific to Namibia that have been shown elsewhere to both impact healthy behaviours, as well as to facilitate the spread of rumours targeting health interventions.

ACKNOWLEDGEMENTS

Getting a thesis off the ground is a solitary task in many ways; in others it is a group effort, more easily helped along its way through the sharing of ideas, experience, support, and sometimes even a few beers with the people who surround you. These are a few of the people who I would like to thank for sharing some or many of these things with me.

I would first like to thank Dr. Richard Lee for first sparking my interest in medical anthropology, and giving me the opportunity to conduct research on the cultural aspects of HIV/AIDS internship in Namibia in 2004. During this internship, I gained the friendship of Dr. Robert Lorway, whose support and endless recommendations proved essential to the development of this text. Similarly, thanks to Gerhild Kölling, librarian at UNICEF Windhoek, for directing me towards much of the literature on Namibia that I made use of here. I would also like to thank my supervisor Dr. Homa Hoodfar for many interesting conversations and for sharing her much appreciated insights on family planning policies across the globe. Likewise, thanks to my advisor, David Howes and my reader, Fran Shaver, for their insightful comments to the thesis.

I would like to thank my family for their emotional and financial support, and for their understanding throughout the long and busy fieldwork and writing stages. Thanks also to Rémy Rouillard for his occasional distraction from and valuable comments to this thesis.

I would like to acknowledge financial support for my studies and fieldwork from the Ministry of Training, Colleges and Universities under the Ontario-Quebec Fellowship in 2005-2006, as well as from Concordia University through the Concordia Graduate Fellowship in 2006.

Finally, I would like to thank my friends and informants in Namibia for sharing their time and thoughts with me, and for allowing me their friendship as well as a small window of insight into the complexities surrounding HIV/AIDS in Namibia.

TABLE OF CONTENTS

Acknowledgements.....	iv
List of Figures.....	vii
List of Tables	viii
Abbreviations and Acronyms	ix
Introduction: Use Condoms! Top Score!	1
Target Groups and Methods.....	8
Some Reflections on the Research Process	11
Criticisms of Western Research on AIDS in Africa	13
Organization of Thesis.....	15
Chapter 1: Situating the Field.....	17
Background to the Study.....	17
Situating Namibia	17
Recent History	19
Churches and Religion.....	21
HIV/AIDS	23
The State, Health and Family Planning	25
Condom Distribution	28
Chapter 2: Managing Misinformation and Maladies: The relation of Public health to rumour	31
Public Health and the Management of Misconceptions	32
Why the Rumour Mill Continues to Turn.....	37
Discursive Resistance	38
Epidemics of Mistrust.....	41
Rumour as Strategic Action.....	42
Summary and Conclusion	44
Chapter 3: Questioning the Safety of “Safe Sex”: Young Namibians Reinterpreting the ABCs of HIV	46
Major condoms brands in Namibia.....	47
Generalized Mistrust in Condoms	50
Mistrust in Ministry Condoms	52
Just Smile?	56
Branded Condoms.....	58
Testing Condoms	59
Discussion.....	62
Summary and Conclusion	68
Chapter 4: Faith in God, Faith in Condoms: Churches and Competing Visions of HIV Prevention	71
Doubting Condoms Internationally.....	72
Doubting Condoms in Namibia	76
Uganda as Exemplar	81
Abstinence and Faithfulness	85
Beyond the Pulpit.....	86
But are the Messages Taking Hold?	90
Discussion.....	91

Summary and Conclusion	95
Chapter 5: Easy as ABC: Public Health Approaches to HIV Prevention in Namibia	
.....	98
Is Knowledge Power?	100
Cultural Barriers, Rumours and Myths	111
Summary and Conclusion	116
Conclusion.....	119
Limitations of Research	120
The multiple meanings of “safe sex”	121
Recommendations.....	124
References	129

LIST OF FIGURES

Figure 1: Outside the Dolam shop	2
Figure 2: Map of Namibia.....	18
Figure 3: Pentecostals and Charismatics in Africa	22
Figure 4: Maximum Gold package	48
Figure 5: Cool Ryder package	48
Figure 6: Smile package.....	50
Figure 7: Smile Water Leakage Test	61
Figure 8: Smile Pinhole Testing	61
Figure 9: SMA Condom Ad.....	101

LIST OF TABLES

Table 1: Number of Interviews and Observations	11
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ABBREVIATIONS AND ACRONYMS

ABC	Abstain, Be Faithful, use Condoms
AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-retroviral
ASO	AIDS Service Organization
CCN	Council of Churches in Namibia
CDC	Centres for Disease Control
CSM	Condom Social Marketing
DFL	Doctors for Life
FBO	Faith-Based Organization
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
HLI	Human Life International
LGBT	Lesbian, Gay, Bisexual, Transgender
NaSoMa	National Social Marketing Programme
NACP	National AIDS Control Programme
NGO	Non-Governmental Organization
MoHSS	Ministry of Health and Social Services
PLAN	People's Liberation Army of Namibia
PSI	Population Services International
SADF	South African Defence Forces
SAP	Structural Adjustment Program
SMA	Social Marketing Association
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SWA	South West Africa (contemporary Namibia)
SWAPO	South West African People's Organization
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	The United Nations Development Programme
UNICEF	United Nation's Children's Fund
UNAM	University of Namibia
WCC	World Council of Churches
WHO	World Health Organization

INTRODUCTION: USE CONDOMS! TOP SCORE!

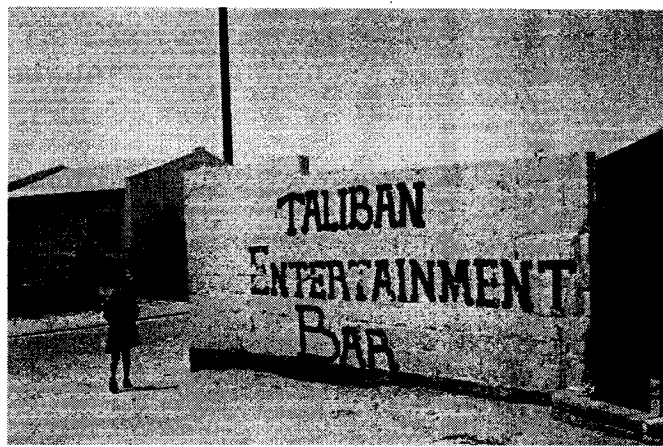
On one hot and dry September afternoon, I receive a call from my friend Tulonga¹ asking me if I want to come along with her to take some photos of people around Katutura. Tulonga had made some friends at a local Faith-Based Organization (FBO), and had been given a camera by the organization as a part of an income generating project they had recently implemented for young women. Tulonga was both taking pictures of an AIDS-related event being put on by another FBO that her brother and sister were volunteering for, as well as collecting money from customers who had had their photos taken by her earlier that week. I tell her I'll meet her there in twenty minutes.

I hail a gypsy taxi to Katutura, or rather to "Tura!", as the taxi drivers say when they call out their windows to pick up potential passengers. Katutura is Windhoek's largely black township, and means "the place where we do not stay" in the Otjiherero language. It was named thusly in 1959 after the massacre and forced removals of black Namibians living in the previous township location. Today's 'Tura is far outside of town, nestled between two mountains, purposely hidden from the eyes of white Namibians, many of whom have never (and likely will never) visit the place in their lifetimes. Ubiquitous along the way is the sight of men in their standard blue worker's uniforms making the nearly 10km trek on foot in the hot sun to the township from their day jobs in Windhoek. I tell the taxi driver to drop me off at the Dolam shop, in the Damara Locassie, the place where the Damara ethnic group was historically confined during apartheid and still largely inhabits. He doesn't know what I'm talking about. It's my accent, I know it. I try a few more times and then call Tulonga on my cell phone again

¹ All names are pseudonyms

and tell her to speak to the man. She arranges things in Afrikaans and we're on our way again. The other passengers in the cab smile, wondering why I'm going to Dolam in the first place. I get dropped off at the corner and quickly greet Tulonga, joining the dozen or so volunteers, dressed in red t-shirts, as they snake their way through the township singing what sounds like gospel music. Except they're singing in Damara through the streets, to the tune of popular radio and TV advertisements, about how people should either abstain or be faithful to protect themselves from HIV. The clicks and snaps of

Figure 1: Outside the Dolam shop



the language create a percussive effect, intensified by the clapping and stomping of the volunteers and the passers-by through the sandy streets. The volunteers are greeted by some and mocked by others, although generally their songs are appreciated - children and adults alike dance along to the music as we pass. There's some debate going on within the songs about the generally accepted ABCs of prevention: while a few of the volunteers sing passionately about abstinence and faithfulness, Tulonga's sister Adila doesn't seem to have much faith in faithfulness or abstinence. She challenges the others, singing out "why?!" in response, demanding people to "use condoms!!!!" instead. Her fellow volunteers smile and sing "Top Score!" back to her, following the tune to a jingle for a

well-known brand of maize meal. I ask Tulonga's brother what makes it difficult for people to use condoms in a country where nearly one in four people are currently infected with HIV. "I think that people are drinking all the time – they're not thinking about these things in the moment, and by the time the alcohol has worn off it's too late." The abundance of *shebeens*² in Katutura is difficult to ignore, their corrugated tin roofs and accompanying eccentric names (Friends Only Bar; Mafia Bar No. 2) nestled between every few houses. Often they are the sole financial and social centres in the neighbourhoods, a place for people to meet, to discuss, and presumably to forget their troubles for a few hours. Alcohol use in Katutura seems to me less an illness in itself, and more a symptom of the greater social ills that continue to plague this post-apartheid state.

The volunteers wind their way through the streets to the Katutura Hospital, where they enter, still singing, pausing at the nurses' station to pick up a few boxes of the new Smile condoms recently put out by the Ministry of Health. The nurses look unimpressed, but hand over the condoms anyhow. Many of the youth I've spoken to have described the defiance on the part of the nurses to providing condoms to young people, and how they often take the opportunity to chastise people about their sexual behaviour. Seeing the abrupt way the nurses deal with the volunteers, I see why obtaining free condoms at a clinic might be a harrowing experience for some.

The volunteers wind their way through the wards of the hospital, singing and speaking to the patients they meet along the way, most of whom lie on foam mattresses stained with blood and other fluids left there by previous inhabitants. Those who are conscious and somewhat healthy are glad to see them, happy just to hear their songs. We enter another room where a young girl stays on the AIDS ward, her mother in traditional

² Informal, and more recently formal, neighbourhood drinking establishments

Herero dress sitting beside her. They ask us to pray for them, and the group of us bow our heads as one volunteer leads a prayer in Afrikaans. The look in the mother's eyes is a sad one, although the family seems relieved that people have entered and have shook their hands, have looked them in the eyes, and have acknowledged and accepted what is happening to them. Few of the people I knew would admit to the possibility that the friends and family members they visited so often in hospitals with vague symptoms and indeterminate illnesses could be sick with HIV/AIDS, choosing instead to speculate on any number of other maladies to explain the causes of their extended stays.

We eventually leave the hospital and the group makes some attempts at giving out condoms to the people milling around outside. One volunteer passes some to a male security guard at the hospital, who smiles kindly and takes a few packages. When Tulonga hands some to a female security guard, the woman drops them on the floor. Tulonga picks them up and hands them back to her, whereupon they are promptly dropped again. The guard refuses to look at her, and responds to Tulonga in Oshiwambo, a language she clearly doesn't understand, effectively putting an end to the conversation. As I noticed at another condom social marketing event, where women actively avoided picking up the condoms on display at the event's condom stand, women being seen publicly taking an interest in condoms (and hence sex) is generally not accepted. Walking towards the taxi ring, a few of the male drivers come up to us to collect a few packs of condoms. When I hand some to one young driver, he completely rejects them, claiming, "No, no...I'm allergic to those things. They give me a rash." He continues his justification: "You know, you have to take your chances in life. You never know what could happen, so why worry about such things?" A few women take some packs of

condoms, at first seeming interested, but they become embarrassed once they figure out what they've been given, deciding to return them to Tulonga. Another young man takes a pack of condoms and then requests that I show him how to use them "in person."

Tulonga, the tough lesbian mother of three children who carries a knife for protection against the men who constantly attempt to "turn her around" tells him she can, but he slinks away, tail between his legs. The condom boxes empty and their voices now hoarse, the group makes their way back to the Damara Locassie, eventually dispersing as the sun begins its inevitable descent.

By presenting the description above, I wanted to highlight a few of the numerous themes about condoms and safer sex that recurred throughout the rest of my stay in Namibia among the diverse groups with whom I was in contact. Why were such tensions apparent surrounding the use and provision of condoms among Namibians, just over 20% of whom are infected with the virus that causes AIDS? (UNAIDS 2004:191)

This research attempted to seek at least a partial answer to that question, by mapping the varied beliefs currently in circulation about condoms and safer sex in urban Namibia among three relevant groups. First, young Namibians living in Windhoek, who largely represent the targets of HIV prevention campaigns promoting condom use; second, religious leaders, many of whom would place themselves in an oppositional stance towards these same HIV prevention campaigns; and third, the HIV prevention experts who develop and implement such campaigns, who largely seek to manage and correct the unruly tangles of "misinformation" about condom use and "safe sex."³

³ HIV prevention experts in Namibia largely use the term "safe sex" to describe the variety of practices one can employ (i.e. condom use, monogamy, etc) to reduce the risk of sexually transmitted infections. The term "safer sex" seems to be more widely used in North America, the implication being that the risks of STI transmission can be reduced through safer sex, but not entirely eliminated.

These three groups were chosen because of their integral roles as the targets, critics, or promoters of local HIV prevention initiatives. Youth were chosen as an essential target group for this research because it is estimated that 62% of young people worldwide living with HIV/AIDS are located in Sub-Saharan Africa (UNAIDS 2004:93). Further, youth between the ages of 15 and 24 account for 50% of all new cases of HIV (UNAIDS 2004:14). Youth are most often the targets of the HIV prevention messages seen on billboards, television commercials and in the print media promoting safer sex in Namibia. However, they are also one group who tends to doubt the efficacy of condoms. Hence, they are one of the main groups upon which my research was directed.

In my 2004 research, which I describe in greater detail in Chapter 1, it was discovered that religious leaders were both highly involved in HIV prevention activities emanating from their churches, as well as in the generation of doubts about the efficacy of condoms among their congregants (Rigillo and Shiinda, 2004). Such actions are highly significant given both the importance of religion and the high involvement of churches and FBOs in HIV outreach and care work in sub-Saharan Africa. Namibia is often described as one of the most Christian countries in Africa, with an estimated 90% of Namibians identifying with one of the numerous Christian denominations (Steinitz 2006:95), while churches and FBOs are estimated to comprise one in five organizations engaged in AIDS programming worldwide.

Further, several recent studies (Pfeiffer, 2004; Willms et al., 2004) have explored the ways in which condom promoters, religious leaders, and the targets of public health interventions in Southern African countries interact to generate anxieties about the promotion of condoms for the purpose of HIV prevention. In Namibia, similar tensions

seem to be apparent. Public statements by religious organizations about HIV prevention seem to dissuade their use, sometimes using scientific data to support the claim that they are simply not effective. In a booklet passed on by a student in Windhoek entitled *Let us Fight AIDS*, by Father Mario Cattanio, a succinct appraisal of his view of the efficacy of condoms is offered:

The use of a condom does not protect safely against HIV/AIDS, it only reduces the risk. Doctors inform us that there is still a 10-30% risk of getting the killer disease...whatever its effectiveness in particular instances in preventing the spread of AIDS, the condom is also condemned by the Catholic Church for encouraging sexual promiscuity, the very behaviour that has contributed greatly to the current widespread incidence of HIV (1999:31).

Materials such as these illustrate that the use of condoms as a way to engage in “safe sex” has been fully accepted neither by young people nor religious leaders in Windhoek. Rather, members of both groups expressed reservations about the safety of condom use, challenging and reinterpreting the information spread by government and international agencies promoting it, albeit in different ways and towards different ends.

Finally, HIV prevention experts play a crucial role in the development and dissemination of information about safe sex and condom use, promoting the campaigns and products that have become the targets of popular suspicion about condoms. The experts I interviewed were cognizant of the counter-discourses toward condoms in Namibia, many of them concerning themselves with development of strategies that aimed to address the popular mistrust in the efficacy of condoms. Such experts largely identified these discourses as “rumours” or “myths”, with a tendency to discount them as a form of misinformation or ignorance that should ideally be replaced with scientific knowledge for the intervention to be successful. Such scientific knowledge is promoted as being “true”

and “objective”, and is the type of knowledge that public health experts desire their targets to adopt.

As Paula Treichler (1999) notes, HIV is a fatal infectious disease whose nature, etiology, and transmission remains poorly understood by science; in the face of these uncertainties, people’s imaginations give birth to many different conceptions, in the form of rumours, conspiracy theories, and alternative knowledge frameworks. Treichler argues that to label these *misconceptions* implies that “only ‘facts’ can give birth to proper conceptions, and that only science can give birth to facts” (1999:16). In order to break out of the impasse created by conceiving of these discourses as rumour, and hence to inadvertently label them “misconceptions”, I instead explore the ways in which both young people and religious leaders engage with the information and products disseminated by condom promoters, in order to arrive at distinctive notions of “safe sex.” Such notions do not map neatly on to those generated by HIV prevention experts, whose position is neatly summed up in the tagline accompanying one series of posters and billboards that recently appeared around Windhoek: “safe sex saves lives.” Instead, for many of the young people and religious leaders I spoke to, sex with a condom wasn’t altogether viewed as “safe”, and instead was perceived as capable of placing people’s lives in danger.

Target Groups and Methods

Given that this research sought to understand the connections and interactions between youth, religious leaders, and condom promoters, the methods were deliberately *eclectic* (Rapport and Overing, 2006), employing different types of interactions with multiple groups in an attempt to represent the diverse field of individual and institutional beliefs relating to safe sex and condom use.

Four major research methods were used towards the collection of the data used in this thesis: participant-observation, structured interviews, focus group discussions, and the collection and analysis of HIV prevention materials stemming from public and international health organizations in Namibia. Research was conducted among three main categories of informants: youth, religious leaders, and HIV prevention experts working out of governmental, non-governmental, and faith-based organizations.

Activities which I participated in and observed included church and religious services, public HIV prevention events, such as National Condom Promotion day, and the day-to-day activities of FBOs and Non-Governmental Organizations (NGOs). Engaging in such activities allowed me to interact with people on a more casual level and to observe the ways in which diverse messages about HIV prevention were presented to target audiences.

I conducted six semi-structured focus group discussions (FGDs) among male and female students attending high school or university between the ages of 15 and 25, and used data from a further six FGDs conducted in 2004. The twelve focus groups comprised approximately 25 males and 41 females, and were sex segregated largely in order to minimize the possibility that participants would try to adhere to any normative gender or sexual expectations that may have been imposed by members of the opposite sex. For example, young men would often tell me that “nice girls don’t carry condoms”, or “women should be totally against sex.” For this reason, sex segregation helped not only to increase levels of comfort and communication, but also helped to prevent women from later becoming the targets of discrimination by their male peers for expressing views did not meet gendered expectations. Although the focus groups were sex

segregated, attitudes towards condoms tended to be similar between the sexes. I also conducted one-on-one interviews and engaged in informal discussions and activities with approximately twenty young people in order to get a better sense of their opinions on safe sex and condoms in more informal situations.

I chose to interview ten religious leaders from diverse denominations, such as Pentecostal, Catholic, Lutheran, and Seventh Day Adventist churches, in an attempt to gain a broad understanding of religious leaders' sentiments towards condom promotion. However, I largely focus on the opinions of Pentecostal religious leaders in this thesis, whose churches are particularly active in the field of HIV care and outreach, and yet who tend to be least incorporated into broader HIV prevention initiatives being undertaken by the government and other mainline religious organizations.

Eleven interviews were conducted with experts working on HIV prevention in government, NGOs, and FBOs, such as the Social Marketing Association (SMA), The National Social Marketing Programme (NaSoMa) and the Namibian Ministry of Health and Social Services (MoHSS). I focused upon this group largely to gain an understanding of their positions on condom promotion in HIV prevention, as well as their approaches to managing "misinformation", resistance and rumours relating to contraceptives and HIV prevention campaigns.

To get a sense of the ways in which knowledge about HIV and the best ways to prevent it is presented to target audiences, I also collected and analyzed written and informational materials (brochures, pamphlets, etc) pertaining to the promotion of safe sex and condom use emerging from both secular and religious spheres. These materials were collected both in 2004 and in 2006, and were largely culled from daily newspapers,

schools, government offices, and the library of the Namibian Ministry of Information and Broadcasting. For a breakdown of the number and type of interviews conducted, see Table 1 below.

Table 1: Number of Interviews and Observations

Formal Interviews and Informal Discussions	Number of participants
Religious Leaders	10
HIV Prevention experts	11
Young people	21
Total	42

Focus Group Discussions⁴ (FGD)	FGD Men	FGD Women
2006	3	3
2004	3	3
Total	6	6

Participant Observation	Number of events
Church Services	4
Campus Crusade for Christ Meetings	2
HIV Prevention Events	5
Total	11

Some Reflections on the Research Process

When I arrived in Namibia, I assumed that my second assimilation into life in Windhoek would not be as difficult as the first; after all, I had been there in 2004 and had kept in touch with a number of the friends and contacts I had made previously. This turned out not to be the case. I was charged with the task of making contacts and building rapport with individuals quickly, as my stay was scheduled to not exceed three months. High schools had been on vacation for the better part of my stay, and it was difficult to

⁴ FGDs comprised anywhere between 4 and 8 individuals between the ages of 15 and 25, and in total involved approximately 25 males and 41 females.

organize formal focus groups in schools. I mitigated this shortcoming by focusing on individual interviews and discussions with young people to replace the focus groups.

The topic itself was difficult to approach for a number of reasons. Being raised within the milieu of a Christian religion, I was somewhat familiar with Christian churches and their belief systems. However, it was often difficult to position myself vis-à-vis other Christians, whose beliefs I most often did not share and was sometimes particularly opposed to.

While I thought that speaking to young people about intimate topics such as condoms, their sexual lives and HIV/AIDS would be difficult, I found that these discussions were most often interesting, sometimes humorous, and only occasionally disheartening. Students were often open and candid, taking the opportunity to launch many questions back to me about my own sexual preferences and the ways that sexual relationships worked in Canada.

Another issue was simply that I was labelled an anthropologist. The representation of anthropologists as people who came in quickly to tell Namibians how they were, and then leave, taking their knowledge with them, was one that was brought up by both informants and friends, and was difficult to address. In some ways, my focus on organizations and structures caused some to perceive it as less “anthropological” and more “practical”: I was not presuming to explain a “discrete” cultural group, but rather a phenomenon apparent in an urban society. I agree with the claim that many anthropologists are often guilty of taking the knowledge they generate about the peoples they “study” out with them, further perpetuating inequalities between the West and the Rest. During my research I was struck by the lack of HIV/AIDS research available to

Namibians – it quickly became obvious that far more of this information exists in the libraries of major North American cities than those of Windhoek. In an effort to address this deficit, I have made a commitment to send this thesis back to a number of libraries and organizations in Windhoek to make it available to those interested in the topic. Still, before proceeding, I would like to highlight some of errors made by previous researchers, if for no other reason than to avoid repeating them.

Criticisms of Western Research on AIDS in Africa

The African continent has disproportionately borne the burden of AIDS infections globally. In 2006, UNAIDS estimated that almost two thirds (63%) of those infected with HIV are living in sub-Saharan Africa – nearly 25 million people (UNAIDS 2006:1). Due both to the interest sparked by the ambiguities surrounding its emergence in the early 1980s, as well as its current status as an epidemic, both quantitative and qualitative research on HIV/AIDS has been and continues to be abundant.

In the past, but also in certain circles today, popular and scientific discourses on “African AIDS” tend to subsume considerations of structural inequalities in favour of a focus on the perceived “cultural” and sexual differences believed to disproportionately increase the discursively homogenous “African’s” risk of becoming infected with HIV (see Farmer, 1992; Marshall, 2001; Oppong and Kalipeni, 2004; Patton, 1990 and 2002 for some relevant critiques). Such discourses were often couched in the language of “objective” scientific research, although they sought to delineate the dysfunctional sexual, moral and cultural practices of Africans from those of Westerners. Such a perceived dysfunctionality has historically been identified by scientists as being instrumental to the genesis of HIV, spurred by Western fantasies about the Other: sex in brothels with monkeys, voodoo rituals and cannibalism were all put forth as credible

disease genesis theories by largely Western academics and experts. Few (if any) of these claims were bolstered by credible research (Farmer 1992:227).

While scientists may have recently toned down their exoticization of the African Other in their project of mapping out the social aspects of HIV/AIDS, popular media discourses continue to promote this stereotypical dualism between Westerner and African. A recent CNN.com article described the factors contributing to the spread of AIDS in Africa as “poverty, ignorance, the prohibitive cost of AIDS drugs, an aversion to discussing sex and, some say, promiscuity” (Christensen 2005:para. 17). All of these factors are tacitly juxtaposed to those that are believed to protect normalized Westerners from HIV infection, such as wealth, knowledge, access to medical treatment sexual openness, and chastity/monogamy. While poverty and the cost of AIDS drugs are recognized, what’s lacking is an acknowledgment of the ways in which legacies of colonialism and the inequalities of the free-market economic system have contributed to shaping the present-day conditions upon much of the African continent.

Condom use has also been identified as one characteristic distinguishing Africans from Westerners, another way to construct an artificial difference that explains why the former exhibits a higher risk of contracting HIV. As Patton (1997) noted in her analysis of AIDS information materials produced by a British aid agency, condom use is perceived to be a rational, health-seeking practice typical to Westerners, where in contrast, “African sex is still considered profoundly natural, too close to the body and its supposedly prediscursive desires to be able to accommodate the inhibiting condom” (Patton 1997:287).

What such discourses inevitably mask is the impact of the structural conditions that have been proven to shape risk for HIV infection. It is apparent that the globalization of trade and the system of international development has led to a system whereby developing countries are home both to the greatest levels of poverty and income inequality. As Farmer (2005) explains, one result of these economic disadvantages is a sort of “structural violence” – an “invisible hand” of a different sort, the type that is usually embodied in racism, sexism and poverty. These processes are “structured by historically given (and often economically driven) processes and forces that conspire...to constrain agency” (Farmer 2005:40). This constraint of agency, exacerbated by disadvantageous economic conditions such as Structural Adjustment Programs (SAP), is arguably one of the primary determinants of the relatively high rates of HIV infection in sub-Saharan Africa (Lurie et al., 2004; Schoepf, 2004). It is precisely this structural violence that the discourses about “cultural differences” increasing Africans’ risk for HIV serve to efface.

Rather than assuming that doubts about condoms in Namibia are due to an essentialized African “hypersexuality” that precludes their use, I seek to examine individuals’ statements and beliefs about condoms, placing them within the wider social context in which they circulate.

Organization of Thesis

For ease of reading, chapters two through five conclude with a section that summarizes the main points of each chapter. The first chapter introduces the field site, as well as providing a brief focused history of Namibia. *Chapter two* explores the ways in which public health experts relate to rumour, juxtaposing this approach with the ways in which diverse social scientific research has theorized the presence of health rumours among

diverse populations. *Chapter three* explores young people's attitudes towards condoms. In this chapter, I argue that the brand and cost of a condom is integral to young people's assessments of condom safety. To young people, sex was considered safest with the use of reputable condom brands, while free "Ministry" condoms were perceived as being the least capable of protecting individuals from HIV. *Chapter four* explores religious leaders' attitudes towards condoms, as well as the ways in which they engage with the scientific knowledge that constructs condoms as safe and healthy choices in an epidemic of HIV/AIDS. It then explores the ways in which religious leaders use this knowledge to support their opinion that abstinence and faithfulness as the sole "healthy" behaviours capable of protecting individuals from HIV. *Chapter five* explores the ways in which information and knowledge about safe sex and condom use is promoted by HIV prevention experts as the primary actions that will help to end the epidemic in Namibia. In this sense, safe sex is perceived as an individual action liberated from the social context which frames many young Namibian's sexual experiences, hence shaping their risk of becoming infected with HIV. In the *conclusion*, I argue that the discourses challenging expert definitions of safe sex are not being adequately addressed by the HIV prevention campaigns currently in circulation in Namibia, and offer several recommendations to correct this deficit.

CHAPTER 1: SITUATING THE FIELD

Background to the Study

This thesis builds upon data gathered in 2004 as an intern under Dr. Richard B. Lee's Toronto-Namibia internship on the Social and Cultural Aspects of HIV/AIDS in Windhoek. During this time, I undertook a research project on youth attitudes towards socially marketed and free condoms in Windhoek, collaborating with Lusia Shiinda, a nursing student from the University of Namibia. The major findings of that project concerned young people's reported lack of trust in government-supplied condoms, as well as the circulation of rumours about condoms in general by young people (Rigillo and Shiinda, 2004). While I learned a great deal about young people's interaction with socially marketed condoms and condom promotion campaigns, I wanted to learn more about how interested groups interact with one another on the question of condom promotion for HIV prevention. The research for this thesis constitutes an attempt to further explore the ways in which young people, religious leaders and HIV prevention experts differently conceive of safe sex and condom use for HIV prevention, as well as their potential impact upon the success of health promotion initiatives in Namibia.

Situating Namibia

This research was conducted primarily in Windhoek, the centrally located capital of Namibia (Figure 2). According to the 2001 Namibian census, Windhoek has a population of 250,305, although in the last few years increasing numbers of migrants have continued to flock to the informal settlements surrounding the capital in search of work and better financial opportunities. Namibia's colonial history, which began in 1884

Figure 2: Map of Namibia



Source: www.ciafactbook.org

with German colonization and ended in 1990 when South Africa eventually relinquished its right to the territory, has left a palpable geographic division along racial lines that remains to the present day in Windhoek. The township of Katutura lies eight kilometres northwest of Windhoek, the area where blacks were forcibly confined from 1968 until independence in 1990. Katutura was further divided into “Locations” that segregated residents by ethnicity, although newer post-independence locations, such as Babylon and Wanaheda,⁵ are home to a variety of linguistic and cultural groups. In addition, Khomasdal is the area previously designated for “coloureds”⁶. Both groups still largely inhabit these areas, although the end of apartheid and increasing economic opportunities have led to many blacks and coloureds moving to areas previously reserved for whites. In

⁵ Named for the combination of *oWambo*, *Nama*, *Herero* and *Damara* groups that live there.

⁶ In Namibia, the term “Coloured” is an apartheid-era racial category that is still used today to refer to largely Afrikaans-speaking mixed race individuals.

order to gain a representative sample, research was carried out across the Greater Windhoek Area, including the townships of Katutura and Khomasdal.

Recent History

The Republic of Namibia is located in Southern Africa, bordering the South Atlantic Ocean, South Africa, Angola, Botswana and Zambia. Namibia, formerly called South West Africa (SWA) by its South African colonizers, officially gained its independence in March, 1990, which has earned it the appellation of the last African colony. From 1884-1915, Namibia was controlled by the German colonial administration, until the country's defeat in WWI. By the terms of the Treaty of Versailles, Germany was stripped of its colonies, and South Africa was given the responsibility of administering SWA under a League of Nations mandate in 1920. After the dissolution of the League of Nations in 1946, the UN requested that South Africa relinquish their claim to the territory and turn over its administration to them. This request was refused, thus beginning a decades-long process of negotiations while South Africa continued its administration.

Throughout its administration of SWA, South Africa actively pursued a joint policy of apartheid and European immigration to the territory, and began the establishment of segregated rural areas for Africans, or *Bantustans*, as well as townships in the urban areas (Africa Watch, 1992). This policy of forced removals, combined with laws passed to regulate the movement of all blacks, contributed to the creation of a vast pool of male labourers to work in white areas, mostly separated from their wives and children, who were prevented from accompanying them to the towns. Pendleton (1974:18) notes that this system of migrant labour negatively affected traditional family structures, leading to a high incidence of extra-marital sexual relations, divorce, and alcoholism, factors today implicated in the spread of HIV/AIDS. Blacks were subject to

prosecution if found without the identification documents required under the “Pass Law system”, and were prohibited from being on the streets at night. Between 1958 and 1959, a campaign of forced removals was pursued to remove blacks from the black settlement in Windhoek now known as the Old Location. Although the area was “informal”, families had lived there for generations, and possessed holding rights to the land (Africa Watch, 1992:15). Blacks would be relocated to the township of Katutura, while the mixed race population (locally referred to as “coloureds”) would be relocated to a separate township, Khomasdal, that offered better housing and facilities. Widespread dissent ensued, culminating in 1959 with a confrontation between protestors and police, resulting in the deaths of eleven people (Pendleton 1974:28). By 1968 the Old Location had been officially closed and the remaining residents relocated to Katutura and Khomasdal. Windhoek’s city centre was henceforth reserved for habitation by whites.

In August 1966, the South West African People’s Organization (SWAPO) and its military wing, the People’s Liberation Army of Namibia (PLAN), instituted the first of many armed struggles against the South African Defence Forces (SADF) in a bloody twenty-three year long war of independence. Torture, “disappearances”, summary executions, and detentions without trial were practiced on both sides of the conflict, and often involved civilian populations. Namibia officially proclaimed its independence from South Africa on March 21, 1990. The country was led from that point by President Sam Nujoma, former head of SWAPO, who succeeded in changing the constitution to allow him to run three consecutive five-year terms in office. He was succeeded by SWAPO founding member Hifikepunye Pohamba, who took office as president on March 21, 2005. Following independence, English was established as the official language of

Namibia, although Afrikaans tends to serve as a lingua franca in urban areas, and indigenous languages are widely spoken.

Churches and Religion

Christianity is the major religion of Namibia, comprising about 90% of the population (Steinitz 2006:95). The largest denomination is the Lutheran Church, comprising about 50% of the population, followed by the Roman Catholic Church.

The first religious missions to Namibia were carried out in 1805, by the London Missionary Society and the Wesleyan Missionary Society in the mid- to late 1800s. At this time, mission stations, churches and schools were established and conversions began by various Lutheran denominations, the German Rhenish Missionary Society, and various Catholic denominations (Nambala 1994:68). During this time, and largely until independence, the majority of churches in Namibia were segregated by race.

The mainline churches in Namibia were intimately involved in the country's liberation struggle; by the early 1980s, the Council of Churches in Namibia, representing over 80% of the population, was closely allied with SWAPO's policies and actions, "serving, in some respects, as an alternative internal wing of the organization" (Steenkamp 1995:96). The Lutheran church was also intimately involved in the liberation struggle, describing itself as a "voice for the voiceless" at this time, offering refuge and support to oppressed Namibians. A growing politicization of the church was apparent by 1971, with Lutheran Bishop Auala's issue of the Open Letter to then South African Prime Minister, B.J. Vorster. The letter appealed to his government to take cognizance of the fact that its apartheid policies were in direct violation of Universal Declaration of Human Rights, and called for the self-sufficiency and independence of Namibia from South Africa. The church both exposed the state's repression and was able to "formulate a

liberation theology rooted in local experience” (Steenkamp 1995:96). At the same time, it also played “a meaningful role in educating and supporting Namibia’s emerging leadership” (Steinitz 2006:95). For these reasons, church leaders are not only highly respected by the general population in Namibia, but “Namibia’s current political and social elite [also] hold the political role of the church in high regard” (ibid).

Pentecostalism, also known as “Born-Again Christianity”, is a branch of Evangelical Christianity that emphasizes direct experience with God through baptism of the Holy Spirit. Pentecostalism appears to be a growing movement in Africa, adherents currently comprising about 12% of the continent’s total population (Pew Forum, 2006:1; see Figure 3).

However, little historic or demographic information exists on the history of Pentecostal churches in Namibia. Many of them seem to be recent apparitions, some with links to larger US-based churches, while others are completely independent and led by local charismatic leaders. Still others have their headquarters in other African countries. Likewise, no exact estimates on denominational affiliation have been gathered in Namibia, as this indicator is not measured on the national census.

Figure 3: Pentecostals and Charismatics in Africa

PENTECOSTALS & CHARISMATICS IN AFRICA

	1900	1970	1990	2005
Pentecostals and Charismatics (in millions)	0.9	17.0	93.7	146.9
Pentecostals and Charismatics as % of Total Population	0.8	4.8	15.2	16.6

Source: *World Christian Encyclopedia* (2001) and *World Christian Database* (2006)

Source: Pew Forum, 2006

As such, no precise numbers exist on Pentecostal church membership in Namibia. The 90% Christian population statistic cited by the Council of Churches of Namibia was questioned by local Pentecostal religious leaders, who noted that such numbers can be misleading. Statistics on denominational membership are taken from church baptismal registers, and unless an individual decides to excommunicate oneself from one's church, they will remain listed as members, even after they have stopped adhering to the faith. Pentecostal religious leaders thus claimed that many of their congregants were still listed as members of their former churches, thus making the number of adherents to Pentecostalism seem much less numerous than they were. Indeed, many of the individuals attending Pentecostal services who I spoke to admitted that they had previously been members of other churches, some still occasionally alternating between religious services.

Pentecostal religious leaders estimated the number of Pentecostal churches alone to be around 200 just in Katutura, a relatively large number for its population of only about 120,000 inhabitants. Whatever their numbers, their presence is definitely apparent in Namibia, as posters advertising spiritual salvation ("Ensure your Rapture") and bodily healing ("Are you suffering from HIV/AIDS? Witchcraft Attacks?") adorn everything from lampposts to shopping mall bulletin boards, and visitors to Zoo Park, the largest public space in downtown Windhoek, now find themselves the targets of impromptu evangelizing and preaching during the leisurely lunch hour and on sunny Sunday afternoons.

HIV/AIDS

In 1986, the first four cases of HIV/AIDS were reported in Namibia. Eighteen years later, in 2004, the national HIV seroprevalence was estimated at 21.3%, ranging

from a low of 9% in Opuwo and a high of 42.4% in Katima Mulilo (UNAIDS, 2004; MoHSS, 2004). The HIV/AIDS epidemic has caused massive declines in life expectancy: while in 1991 the average Namibian could expect to live to the age of 61, by 2000 life expectancy had plummeted to just 43 years (MoHSS, 2001).

Namibia's history, as well as its current economic conditions, illustrate some of structural factors that have contributed to shaping its population's risk of contracting HIV. Colonialism, apartheid and its attendant health policies, a continuing history of migrant labour, poverty, gender inequality and protracted wars have created an environment amenable to a disease that has been recognized to thrive under conditions of structural violence, particularly among those who inhabit the margins and fault lines of society (Farmer, 1992). Today an estimated 75.9% of Namibian households have an income below the state-defined poverty line, while the unemployment rate is estimated at 31% (CBS, 2001; NPC, 2001). According to the 2004 UNDP Human Development Report, Namibia is home to the highest level of income disparity in the world. The country had a relatively high per capita Gross National Income (GNI) in 2005, of \$2,990 USD, in comparison to the average for sub-Saharan Africa of \$745 USD per capita (World Bank, 2005). Despite the impression of relative wealth given by these numbers, "an estimated 55% of national income accrues to only 10% of the population, and 35% of the population live on less than \$1 per day" (USAID, 2005:1).

Shortly after independence in 1990, four years after the virus was discovered in the country, the National AIDS Control Program (NACP) was launched, charged with the task of managing HIV prevention and outreach activities. In 2003, the Namibian government began its anti retro-viral (ARV) therapy rollout, providing the drugs free of

charge to HIV-positive citizens in major urban centres. Also in 2003, the government began the provision of Nevirapine in hospitals, used to prevent peri-natal HIV transmission between mothers and newborns (MoHSS, 2001). The government has tended to follow the ABC (Abstain, Be faithful, use Condoms) approach to HIV prevention, with a focus on condom use (UNICEF, nd). NGOs and FBOs are also highly involved in HIV prevention and outreach activities: in 2005, the Namibian Network of AIDS Service Organizations (NANASO) counted nearly 160 organizations among its members (NANASO, 2005).

The State, Health and Family Planning

This section explores some key points about pre-independence⁷ health care and contraceptive policies, and attempts to illuminate the historical background which may inform citizens' relationships with family planning in contemporary Namibia.

During the period of South African rule of SWA, the state promoted a form of biological racism that placed blacks and "coloureds" at the lowest rungs of the evolutionary ladder. Such beliefs extended to all spheres of social and political life, including health. As Wallace notes of health care in Namibia, "the colonial regime introduced biomedical practices and institutions as an integral part of its colonizing project", implemented both through the manufacture of consent and the imposition of force (Wallace 2002:43). Health care was seen as a service that aimed primarily to protect the health of the colonizers and to keep non-white workers' bodies at the minimum functioning level required to serve the apartheid state, although tensions

⁷ Little historical or archival evidence exists about public health policies governing apartheid-era Namibia. As South-West Africa, it was managed as a 'fifth province' of South Africa, and was largely subject to the policies in force there. Some of the historical evidence in this section thus comes from the literature on South Africa, although certain specific Namibian examples have been included.

emerged as it strove to keep the size of non-white populations at “manageable” levels (Wallace 2002:43).

As early as 1939, the administration in South West Africa introduced periodic, compulsory examinations for Sexually Transmitted Diseases (STDs) of all unmarried black women in Windhoek. As Wallace notes, the policy was not developed in response to rising rates of STDs, which seemed to remain stable throughout the 1930s. Instead, the “general ideological climate among policy-makers was of much greater significance in the formation of anti-VD measures” (2002:231). Wallace argues that fears about sexual contamination, interracial sex, and the social breakdown of white families, directed primarily towards “immoral” black women were instead the primary motivators of the campaigns. The STD campaign was met with fierce resistance from women, and was eventually repealed in 1949. In any case, the event “provides a telling example of the importance of the body in as a site of colonizing power and contestation between the colonizers and the colonized” (Wallace 2002:238), one that would be repeated throughout the course of the history of public health in Namibia.

Almost thirty years later, the South African government continued its abusive actions toward the black population, actively attempting to reduce their numbers both in Namibia and South Africa through the forceful and covert injection of hormonal contraceptives, namely, Depo-Provera (Hartmann, 1995). Beginning in the 1970s, a national family planning program was implemented in Namibia, constituting the sole free of charge health service provided to citizens. The program was based on a broader state policy of “population control”, which included policies to control population movement and to restrict migration, such as the practice of segregating black and white populations

by restricting blacks to designated areas (Lindsay 1991:144). While the long-term health effects of Depo-Provera were unknown at the time, hospital personnel were found to have administered higher than recommended doses of the injection to black women “immediately after childbirth, often without the woman’s consent or knowledge” (Lindsay 1991:145). Such injections were also given to girls as young as thirteen, often without the knowledge of their guardians. Other recorded abuses of medical intervention upon women included the “insertion of intrauterine devices and operations for sterilization and hysterectomy, without permission or after the use of bullying and blackmailing techniques of persuasion” (Lindsay 1991:158). Such practices were reported to have continued into the 1990s, and some women I encountered throughout the course of this fieldwork reported either having themselves been affected by such initiatives, or knowing someone who had been.

Beyond the use of Depo-Provera, the South African state considered even more inhumane and covert forms of population control. During the Truth and Reconciliation Commission (TRC), it was established that health professionals and scientists were intimately involved in the military’s chemical and biological warfare (CBW) program. The goal of the program was to create compounds that would kill groups and individuals that threatened the state, while making the cause of death seem natural. Compounds reported to be under investigation included anthrax in cigarettes, *C. botulinum* in milk and paraoxon in whiskey (TRC 1998 in Baldwin-Ragaven et al. 1999:155). Also in development were programs to control black fertility: one of the most important projects in the early stages of the CBW programme was “work done by scientists to develop an anti-fertility vaccine that could have been used clandestinely on black people.” Related to

controlling the “communist threat” facing South Africa, such programs were characterized by a certain level of international cooperation, as evidenced by support from the United States and other Western nations. (Baldwin-Ragaven et al. 1999:156).

During the liberation struggle, the South West African People’s Organization (SWAPO) and its proponents denounced the injustices relating to family planning under the apartheid system as being entirely antithetical to the rights of citizens in a free and democratic Namibia. Prior to independence, SWAPO politicians and opinion leaders carried out a pro-natal campaign as one way of mobilizing the public against the apartheid government, claiming that “family planning programmes were designed to undermine the black population in the country”, and that Namibia, with its vast, sparsely-populated territory, required more Namibians to become stronger (Ahrenson-Pandikow 1992:4). According to Ahrenson-Pandikow, the resonance of such arguments, as well as the imposition of restrictions on the promotion of contraception, “posed a barrier, which is said to persist still, to the effective acceptance of birth control measures” (Ahrenson-Pandikow 1992:4).

Condom Distribution

Free condom distribution formally began with independence in 1990 with the launch of the National AIDS Control Program (NACP) (!Goraseb, 2006). The practice of the social marketing⁸ of condoms began in the mid-1990s, when a lack of resources and

⁸ Social marketing (SM) is perhaps one of the most widely used market-based approaches to health promotion today, first developed by Philip Kotler and Gerald Zaltman in 1971. It is defined as “...the design, implementation and control of programs calculated to influence the acceptability of social ideas and involving considerations of product planning, pricing, communications and marketing research” (Kotler and Zaltman 1971:5). SM essentially applies the tenets of commercial marketing to elicit social change, in an attempts to facilitate positive changes in the health status of populations. Since its inception, social marketing has been applied to the correction of a panoply of health problems, ranging from the promotion of condoms in developing countries to campaigns against obesity in the United States. It has also been heavily critiqued on the grounds that it is incapable of addressing the complexities of human behaviour

infrastructure prompted the MoHSS to contract out condom production and promotion to the Social Marketing Association (SMA), a subsidiary of the Washington-based Population Services International (PSI). In February 2006 the government released *Smile*, a condom which resembles the packaged socially marketed brands currently on the market, although it is distributed free of charge. Unbranded condoms wrapped plainly in silver foil packaging are also available free in clinics and government offices.

In 2004, the percentage of Windhoek youth who reported that they used a condom consistently with their regular partner was 71.7% for youth aged 15-24, and 69.8% for youth aged 16-19 (UNICEF, nd). However, in 2005 it was reported that 39% of young Namibian women are either pregnant or mothers by the age of nineteen - a clear indicator that young people are indeed having presumably unprotected sex (UNICEF, nd).

Negative sentiments towards condoms appear to be widespread among young Namibians. For example, a 2001 study of Katutura adolescents found that 28.9% of grade 8 students associated condoms with promiscuity, agreeing with the statement that women who carry condoms are “cheap” (Yamakawa 2001:150). The attitude that condoms serve to reduce sexual pleasure is one that also appears to be common across Namibia, with a number of studies describing Namibian men’s perception of condom use as akin to “eating a sweet with the wrapper on” (LeBeau et al., 1999; Mufune, 2005; Yamakawa, 2001). What many describe as “rumours” and “myths” questioning the safety and efficacy of condoms are also widespread (Iipinge et al., 2004; Mufune, 2005). How can the spread of such rumours be explained? The following chapter first explores the ways in which public health experts understand and address rumours surrounding health interventions, usually

(Maibach, 2002), that its fee-for-service model impedes access to its services and products by the lower classes (Price, 2001), and that it neglects issues of trust and consensus building within target communities in its efficiency driven, top-down approach to health interventions (Pfeiffer, 2004).

as a form of simple misinformation that should be replaced with biomedical “facts.” It then deconstructs this assumption, presenting research that elucidates the wider social forces implicated in the spread of health-related rumours.

CHAPTER 2: MANAGING MISINFORMATION AND MALADIES: THE RELATION OF PUBLIC HEALTH TO RUMOUR

Throughout my fieldwork, what HIV prevention experts inevitably identified as “rumours” about condoms proliferated among young people: the belief that government-issued condoms were more likely to fail to protect users from HIV, for example. A hierarchy seemed to be emerging among young people, where more expensive condoms were perceived as being safer, leading to the Ministry of Health’s release of the free, branded Smile condom, in an effort to renew popular trust in the government’s prophylactic offerings. Despite this, youth continued to engage with and challenge the expert information they had been given, their views often contradicting the official conceptions of “safe sex” which public health experts wished they would internalize.

Young people identified their churches, pastors and priests as places where questions about condom efficacy were initially encountered. Subsequent interviews with religious leaders confirmed that many of them also had little faith in condoms, and accordingly understood safe sex in terms that differed significantly from official definitions. What’s more, religious leaders took a distinct approach in giving substance to what might be discounted as simply hearsay or rumour: they actively engaged with scientific research to give weight to their claims that condoms were ineffective. Public health experts also identified these discourses as “rumour”, or a form of misinformation, in expressing their agitation at these perceived attempts to undermine the promotion of condoms.

With these two examples, I wish to illustrate the disjunctures that often emerge between the official knowledge disseminated by public health authorities and the

knowledge that results when individuals and groups engage with official discourse, coming to conclusions which may diverge from, or even outright challenge expert knowledge about HIV prevention. What I wish to examine in this theoretical chapter is the ways in which these dissenting discourses are disregarded by public health experts. In discounting rumours, public health experts largely construct them as an irrational discourse, thus setting up an oppositional relationship between the “official” knowledge stemming from the expert sphere and the “unofficial” knowledge stemming from non-experts. What I wish to argue here is that rather than being simply the result of ignorance, the generation and spread of rumours about health interventions are influenced by both contemporary and historical social circumstances and fill distinctive social needs, complexities which are largely ignored by public health experts.

Public Health and the Management of Misconceptions

One could use a number of theoretical tools to make sense of what could easily be discounted by some as irrational fears about health and disease. Terms such as “myths”, “misconceptions”, or “traditional beliefs” often appear in the HIV prevention literature to describe discourses that challenge dominant biomedical knowledge about HIV/AIDS. As Treichler (1999) notes, HIV is a fatal infectious disease whose nature, etiology, and transmission still remains poorly understood by science; in the face of these uncertainties, people’s imaginations give birth to many different conceptions, in the form of rumours, conspiracy theories, and alternative knowledge frameworks. Treichler argues that to label these *misconceptions* implies that “only ‘facts’ can give birth to proper conceptions, and that only science can give birth to facts.”(1999:16). Treichler notes that science has often been wrong in its estimations of the disease, for example, its contention that HIV/AIDS was a disease specific to homosexuals that could only be transmitted among men. “Such

assertions blur the line between the facticity of scientific and nonscientific (mis)conceptions”, disguising the ambiguity and contradiction inherent in scientific discourse, and instead associating such qualities with discourses emerging from nonscientists (Treichler 1999:16).

When public health experts address what they call rumours, they are likely to ground themselves in such a conception/misconception dichotomy: Rumours are viewed as a type of belief, where “belief is used to connote ideas that are erroneous from the perspective of biomedicine and that constitute obstacles to appropriate behaviour” (Pelto and Pelto 1997:148). From this perspective, the knowledge of the non-scientific other must be *corrected* and replaced with “modern” scientific knowledge for a health intervention to be successful. For example an article in the journal *Population Reports* (1995), describes the ways in which public health experts should counter rumours in the media about family planning in developing countries:

In some places false rumours about reproductive health are widespread and scare some people away from contraception—for example, "the pills build up in your stomach;" or "vasectomies are castration"; or "an IUD can travel to a woman's brain." Family planning service providers are trained to counter such rumours *by counselling clients with the facts*. Help journalists also to counter rumours *by reporting the facts*. Such activities as *preparing fact sheets and background reports on family planning methods and programs*, arranging interviews with service providers and clients, and making family planning programs more accessible to journalists will help the news media see rumours for what they are. *The more people who know the facts, the more who are in a position to stop rumours from spreading* (emphasis added).

The report further counsels public health experts to “support their facts with solid evidence” and to “put journalists in touch with community experts and to provide scientific evidence from international sources such as the World Health Organization” (Population Reports, 1995). The fetishizing of scientific *fact* is difficult to ignore; the

assertion of its power and supremacy is thus perceived to be the primary way of quashing health-related rumours, while little attention is paid to the reasons why such rumours may resonate within communities.

One issue is the propensity to use Western concepts of health and disease in health promotion initiatives, which may cause experts to identify local concepts as “rumours.” Nichter and Nichter’s (1989) research on Sri Lankan villagers’ experiences with modern family planning methods illustrated, rumours about side effects stemming from use of the birth control pill incorporated pre-existing ideas of Western medicine as bringing about toxicity and “heatiness” in users, as opposed to traditional herbal medicines, which rendered control and balance. The pill was viewed not in the Western sense as a temporary contraceptive method, but as one which would cause the uterus to dry up and a woman to eventually become infertile. While the symptom of heatiness as a side effect was the one most commonly reported among Sinhalese informants, it was never mentioned in local public health reports about contraceptives, because the side effect profiles used in local survey instruments were adapted from those reported by Westerners. What is apparent from such research is that attempting to discount culturally-specific understandings of health does not remove them from existence. Such different forms of knowledge about health and disease are not easily discredited or replaced with biomedical fact, especially with an area as emotionally and physically fraught as fertility regulation (Nichter and Nichter 1989 60-77).

However, a more communicative approach between public health experts and the publics they target may be precluded because of the unequal power relations existing between these groups. Charles Briggs (2002) sees public health’s approach to knowledge

as resulting in a dichotomy between what he calls “sanitary citizens” and “unsanitary subjects”, the latter being “persons who were expected to have failed to internalize medical epistemologies, bodily practices, and deferral to health professionals” (Briggs 2003:288). Public health experts assume that unsanitary subjects simply lack the information required to adopt healthy ways of being and behaviours, sometimes choosing to intervene with force if one’s “misconceptions” are not replaced with the requisite ideological and bodily modifications.

The models used to understand the ways in which people internalize health information and translate such knowledge into healthy behaviour are instructive in providing another insight into the ways in which public health authorities conceive of their publics from an “individual, linear and rational perspective” (Airhihenbuwa and Obregon 2000:8). Such a perspective is apparent in the long standing influence of the Health Belief Model (HBM) in explaining and predicting the adoption of health behaviours by individuals (Hochbaum, 1958 in Mantell 1997:181) The HBM posits that rational, strategic individuals are able to “*successfully assess and apply knowledge, weigh costs and benefits, and make a rational choice to pursue the behaviour required to produce desired outcomes*” (Mantell et al. 1997:181 emphasis added). In possession of the required information and the self efficacy⁹ to make the required behaviour change, the reasonable individual is believed to be highly likely to make decisions that will foster good health. However, such rationality is a quality conferred largely upon those who accept the superior knowledge of Western biomedicine, and excludes spontaneously

⁹ Self efficacy is a variable believed to be highly influential in the undertaking of healthy behaviours, and defined as “people’s beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives. Self-efficacy beliefs determine how people feel, think, motivate themselves and behave.” (Bandura 1994:71).

generated, unverified, dissenting or “traditional” knowledge concerning health and disease. Such a valorization of the rational health-seeking individual is apparent in the practice of the social marketing of condoms in Namibia, largely accomplished by product branding and subsidization, and one of the primary ways that the devices are distributed and promoted in the country. Social marketing has been accused of targeting only individual behaviour and focusing on the distribution of information, “consequently reducing public health issues to individual-level problems and defining solutions within ‘information deficit models’” (Guttman, 1997 in Airhehenbuwa and Obregon 2000:8). Beyond their inability to examine and address alternative knowledge about health and disease as anything other than misunderstandings that need to be corrected, these models have been further criticized on the grounds that social behaviours tend to be extremely complex, motivated by much more than simply a lack of information (Bloom and Novelli 1981:80); that more knowledge does not necessarily lead to behaviour change (McKenzie-Mohr, 2000); and that poverty and structural inequalities play a proven role in determining population health (Farmer, 2005).

Defining Rumour

Outside of public health, sociological definitions of rumour also share this conception/misconception dichotomy: rumours are based upon shaky knowledge foundations that would likely crumble if people would only accept “the truth.” Evidence of this construction is found in Allport and Postman’s seminal definition of rumour as “a specific proposition for belief, passed along from person to person, usually by word of mouth, *without secure standards of evidence being present.*” (1947:ix emphasis added) In contrast, contemporary definitions highlight the importance of social contexts and cite the

reasons why rumours are likely to emerge and circulate, as does DiFonzo and Bordia's (2007:13) definition of rumours as "unverified and instrumentally relevant information statements in circulation that arise in contexts of ambiguity, danger, or potential threat and that function to help people make sense and manage risk." Still, the emphasis on the *unverified* nature of rumours perpetuates the distinction between official (verified) and unofficial (unverified) sources of information, privileging the former and denigrating the latter. As Kapferer (1990) notes, this official/unofficial distinction is a holdover from wartime days, when the US government often reminded its citizens that "loose lips sink ships"; thus, rumour mongering and belief in rumours were denigrated as unpatriotic activities, expressions of a lack of trust in official channels of media and government that may have aided the enemy (Kapferer 1990:10). Rumours thus "acquired a reputation of a mental illness affecting the social body" (Kapferer 1990:10), silencing, stigmatizing and discounting those choosing to challenge versions of "official reality."

Why the Rumour Mill Continues to Turn

To examine the characteristics that facilitate the spread of rumours allows one to see rumours in a different light: as reasonable responses to situations sharing certain socially relevant features. As the American sociologist Tamotsu Shibutani (1966) noted, rumours are particularly likely to arise in situations that are both *ambiguous* and *important*. Additionally, Rosnow and Fine (1976:30) identify personal or situational anxiety as essential factors in rumour generation. For example, natural disasters, wars, and racial tensions tend to generate such emotions, often giving rise to rumours. Also similar in nature are epidemics of infectious disease, from polio to HIV/AIDS, which have been identified by anthropologists as sites that are particularly conducive to the spread of rumours. The consequences stemming from the HIV/AIDS epidemic in sub-

Saharan Africa also create a situation of ambiguity because it is disease which had not been known to exist previously in the region, and also because it disproportionately affects Sub-Saharan Africa in particular. It is both important and a cause of anxiety because HIV is spread primarily through sexual contact, forcing changes in the way that sexuality and gender relations are conceived of within society, as well as because it results in illness, death and social upheaval on a widespread scale.

Such catastrophic situations could call for a number of human responses – why is rumour consistently identified as one of the first to emerge? Shibutani (1966) argues that the spectacular events that often trigger rumours create a high demand for information that cannot be met by official channels; thus, rumours emerge as a form of collective problem-solving and meaning-making that attempt to stabilize a situation. In a similar vein, Kapferer (1990:9) calls rumours an “informational black market”, arising when “the public endeavours to understand but receives no official answers.” What’s more, the fact that many “rumours” have turned out to be rooted in recorded or eventually unveiled events give people good reason to believe them: as Kapferer notes, the existence of information leaks and “political secrets” that were later revealed motivate individuals to turn their backs to official discourses, bringing multiple others into being: “to each his own truth” (1990:7). Lacking official answers, or questioning the ones that are given, the generation of rumours may emerge as a way to fill in informational gaps and to endeavour to understand the hidden workings of power that strive to keep the “truth” a secret from the masses.

Discursive Resistance

Rumours and conspiracy theories about public health interventions may, in some cases, be sparked by a lack of information, constituting an alternative mode of meaning-making

and acquisition in the absence of (or opposition to) “official” knowledge. If public health interventions often occur within situations of ambiguity, importance and anxiety, and are accompanied by a lack of official answers, or a lack of trust or belief in these answers, then, according to the theorists above, a situation develops in which rumours are highly likely to emerge. However, a number of anthropologists have explored the emergence of rumours in such situations, and have instead analyzed their content in terms of the ways in which histories of abusive state interventions provide a potent fuel for the rumour mill. This section explores how an examination of the history of state-directed health interventions often provide clues to the content of health rumours, which often implicate the state or international actors as seeking to accomplish malicious rather than benevolent ends through their health interventions.

White (1994) notes that gossip and rumour are diagnostic of responses to both local and national projects, and reveal the “passions, complaints and revisions” that otherwise remain suppressed in public speech. Such rumours, in situations relating to health and disease, have been understood by some as constituting “metaphors that creatively critique and challenge global, biomedical constructs of AIDS” (Stadler 2003:366). However, rather than emerging spontaneously, health-related rumours and conspiracy theories thrive also because of well-documented histories of abuse that have resulted in a lack of trust in the “powers that be.” For example, Nancy Scheper-Hughes argues that rumours relating to organ and body theft in South Africa “are repeated and circulated because they are true at that indeterminate level between fact and metaphor”, testifying to a brutal history of apartheid control and subjugation of the bodies of citizens. In this case, informants revealed that organs and bodies had been and continued to be

both mishandled and appropriated without consent by the state. Thus, “the metaphors are materialized in the grotesque enactments of medical, economic and social relations which are experienced at the immediate level of the violated and dismembered body” (1996:5).

Similarly, the Tuskegee Experiment has been identified by a number of scholars as instrumental in the loss of trust in the government and medical profession that has contributed to the preponderance of health-related conspiracy theories in circulation among African Americans (Rodlach 2006:115). The Tuskegee study, funded by the U.S. Public Health Service, followed 600 syphilitic African American men for forty years, up until the early 1970s. Throughout the study, treatment for syphilis was withheld from participants in order to chart the “natural history of the disease” (Rodlach 2006:115). As Rodlach notes, the legacy of this medical project has passed far beyond the borders of the United States, fuelling AIDS conspiracy theories in his village field site in Zimbabwe.

In contrast, other health rumours may not necessarily be based upon negative collective memories concerning documented historical events, but may instead allude to shared anxieties emerging from present realities. For example, contemporary rumours articulating fears about sterilization have been reported across post-colonial African states (Feldman-Savelsberg et al., 2000; Kaler, 2004). Such rumours speak to real or imagined population control anxieties that may be directed towards the state or to extra-state actors, as the two cases below illustrate. In Cameroon, the sterilization of young girls, thought to be accomplished through a tetanus vaccination campaign, was believed to constitute a government plot to quell political unrest (Feldman-Savelsberg et al., 2000). Feldman-Savelsberg et al. point out that such rumours not only reflected contemporary political anxieties, but also stemmed from a colonial history involving

forced vaccination campaigns, and were further exacerbated by a public health goal-driven approach that emphasized efficient delivery of services over consensus-building and communication. Similarly, Amy Kaler (2004) found that residents of Malawi's Balaka District commonly believed that condoms caused sterility and HIV infection, and that condom distribution was a plot orchestrated by Westerners to reduce the country's population so as to depopulate the country and appropriate its land and resources. Kaler notes that such rumours serve to explain the emergence and local significance of both condoms and HIV in Malawi, and also "express in symbolic form many Malawians' perception of their relationship to the state and to the broader world outside Malawi" (Kaler 2004:113).

Epidemics of Mistrust

As the discussion about abusive state interventions above illustrates, rumour is often also an indication of mistrust generated either by one's own lived experiences, or by the narrated experiences of others. As such, health-related rumours are related in a fundamental way to contemporary relationships of trust between citizens and the state on the one hand, and extra-state actors on the other, such as the governments that provide condoms to HIV-affected countries, as well as the scientists who promote their efficacy. While mistrust can be related to histories of abuse, it has also been explained as being associated with the conditions of modernity, characterized by the attendant belief that scientific reason has largely failed in its project of making the world objectively known and bringing progress to all (Fischer, 1999). Anthony Giddens (1990) sees the reflexive nature of modernity as instrumental to generating an environment of credulity and permanent ambiguity, characterized by a shifting and impermanent knowledge that is inhospitable to the germination of trust. According to Giddens, "we are left with

questions when once there appeared to be answers...a general awareness of the phenomenon filters into anxieties which press in everyone” (1990:49). Such a situation is exacerbated by the presence of seemingly opaque structures such as government, infrastructure and science, or *expert systems*, which organize large areas of the material and social environments in which we live, largely relying on citizen trust to operate effectively (1990:18). Trust is therefore involved in a fundamental way with the institutions of modernity, and is vested not in individuals, but in abstract capacities: the majority of citizens trust in expert systems, such as the public health apparatus, or the scientists and epidemiologists that generate strategies to manage HIV/AIDS, yet often lack intimate knowledge about their operation. Such an ignorance of the knowledge claims of technical experts may create grounds for popular scepticism and caution (Giddens 1990:89).

Rumour as Strategic Action

Rumours are also likely to be spread among communities and groups experiencing social, economic and political marginality. Through rumour, individuals who are subjected to structural violence seek to make meaning of situations and to identify and challenge the actors who are most likely to blame for their misfortunes. Briggs (2004) provides one example of such a process in his study of a cholera outbreak in Venezuela.

Epidemiological experts there described indigenous villagers’ heightened susceptibility to the disease, as compared to non-indigenous people, in terms of imagined “cultural” practices, such as exotic rituals involving the consumption of raw seafood. By circulating rumours that explained the social and political factors that led to indigenous peoples being discursively constructed as “at risk” for the disease, villagers refused to accept such negative depictions of themselves, interpreting and evaluating “official” information and

addressing the “politics of erasure” that lead to issues of race, class and gender to be subsumed in public health discourses on the spread of disease. Briggs argues that while such strategic rumours allow individuals to creatively make sense of their situations, they ultimately fail “to disrupt the ideological construction of how cholera discourse should circulate”, largely because their progenitors lack the materials (means of production, social conditions of access to them, etc) to launch discourses into public circulation (2004:178).

Other groups may encounter more success in the widespread circulation of rumours and counter-discourses about health interventions, as research with certain religious groups have illustrated. In regions where HIV/AIDS is prevalent, Christian communities in particular appear to exhibit oppositional relationships to agencies promoting condoms because the devices, in many cases, contradict religious doctrine. The spreading of rumours and conspiracy theories about condoms by religious groups thus becomes one way of resisting state interventions and helping their congregants to “keep the faith.” This has been observed in two similar studies of resistance to condom promotion by religious groups in Southern Africa. The first, by Denis Willms et al. (2004), reported that faith communities and churches in Malawi saw themselves as “weak, poor and vulnerable” in their efforts to promote abstinence and faithfulness, while groups such as governments and pharmaceutical corporations promoting condoms were believed to succeed because they were strong, voiced, and moneyed. Conspiracy theories abounded in this environment of suspicion and concern, and condoms emerged as a “metaphor for resistance, a symbol of what separates faith communities and their distinctive notions of truth from that of government, donors, and the scientific

community” (2004:30). James Pfeiffer reported a similar backlash against the promotion of condoms by international aid agencies in a highly religious community in Mozambique. Pentecostal pastors there associated the socially-marketed *Jeito* brand condom with a rise in promiscuity that they saw as being implicated in the spread of HIV/AIDS. As a result, many pastors decided to actively preach against condom use to their congregations, spurring the circulation of a rumour among young people that the *Jeito* brand “actually brought the HIV virus to the province, and that *Jeito* could therefore give the user AIDS” (2004:93). These two examples illustrate that rumours can be spread for strategic reasons, especially by groups in possession of the platforms needed to reach large audiences. The spread of and belief in such rumours within populations are aided by the ambiguity, importance, and anxiety characterizing the social contexts in regions highly affected by HIV/AIDS, creating a situation where condoms are being reconstructed as public health hazards rather than the sole barrier method capable of protecting sexually active individuals from HIV infection.

Summary and Conclusion

This chapter explored the ways in which public health experts understand rumours about their health interventions as a form of misinformation that needs only to be corrected with the provision of correct and factual biomedical information. I have attempted to challenge this construct through examining some of the preconditions that facilitate the spread of rumours, such as ambiguous, important, and anxiety-filled situations characterized by a lack of information. Rumours often refer back to actual events, are also likely to be spread in environments where histories of abusive or unethical interventions on the part of the state or other actors may have contributed to a climate of mistrust among the targets of a health intervention. In this sense, negative collective memories about such

interventions are unlikely to be easily forgotten, instead finding new life in the form of suspicious rumours. The ambiguity characteristic of the conditions of modernity may also provide further fuel to the spread of rumours, as in situations where individuals must place their trust in the good intentions of experts charged with managing complex actions such as health intervention and disease prevention. Rather than simply being reactive, rumours can also serve strategic purposes among marginalized communities, such as religious groups, and allow them to challenge the experts who promote health regimes which contradict social and moral codes. What this implies is that rumours about health interventions cannot simply be viewed as being rooted in an ignorance of the correct biomedical knowledge that is believed to allow people to make decisions that would benefit their health. Rather, rumours may be spread for different reasons and under specific circumstances; thus, their discounting as a discourse of misinformation or ignorance by health experts does little to counteract their spread. In the following chapter, I delve more deeply into condom rumours among young urban Namibians, in an effort to better sketch out some of the contextual factors that have contributed to the spread of such rumours among this group.

CHAPTER 3: QUESTIONING THE SAFETY OF “SAFE SEX”: YOUNG NAMIBIANS REINTERPRETING THE ABCs OF HIV

The best things in life are Not for Sale...
- Smile condom bumper sticker

While the government and international aid agencies promote condom use as a reliable and integral component in the prevention of HIV in Namibia, the targets of their programs have not unproblematically adopted this same position. In this chapter, I explore the ways in which young people engage with the expert knowledge that constructs condoms as safe and healthy choices for sexually active people wishing to protect themselves from HIV. I argue that for many of the young people I spoke to, condoms were not perceived as being equally safe; rather, the brand, origin and cost of a condom were integral to young people's assessments of their effectiveness in preventing HIV. To accomplish this, I first provide a brief survey of the condom brands available in Namibia, noting their identifying characteristics. I then explore young people's attitudes towards condoms in general, and then by brand, in order to illuminate the mistrust that tends to permeate their understanding of the devices. The mistrust in condoms often expressed by youth took a specific tone: it was often government-distributed condoms that were believed to be of substandard quality and prone to breakage, while the socially marketed brands were believed to be of higher quality and more trustworthy.¹⁰ I then explore the phenomenon of condom testing, an action that young people undertook to determine their level of efficacy, challenging the scientific knowledge that promotes them as health preserving products. Finally, I explore how brand, place of origin and cost

¹⁰ While this research was able to illuminate what young people say about condoms, and how they are generally perceived, I cannot claim that this translates into knowledge concerning frequency or correctness of condoms use, or which brands are actually used when they are.

intersect to generate new definitions of the practice of “safe sex” that do not necessarily accord with those promoted by HIV prevention experts. Such practices seem to indicate an expression of strategic consumerism as a health-seeking behaviour, as well as an indication of a lack of trust in the government’s ability to provide safe health products to citizens.

Major condoms brands in Namibia

Today a variety of subsidized branded condoms promoted by international and domestic organizations are available in Namibia, colourfully advertised on large billboards throughout the Windhoek area. The government also provides free, silver packaged, unbranded and usually lubricated condoms through its health clinics, hospitals, and government offices. Their packaging indicates that the condoms are produced in a variety of countries, such as South Africa, the United States, and South Korea, although some contention exists over their precise origins, as will be discussed below.

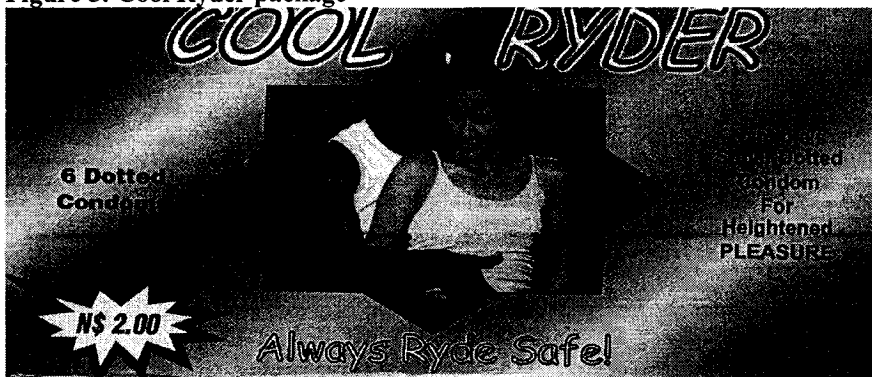
In the past decade, social marketing agencies have become highly involved in the distribution of condoms for HIV prevention within the commercial sector. The Social Marketing Association (SMA), a subsidiary of the Washington-based and USAID-affiliated Population Services International (PSI) began production of its “Namibia’s own” Maximum Gold condom in 1997, primarily marketing it towards truckers and sex workers. SMA attempted to popularize the use of condoms by introducing the concepts of “maximum pleasure” and “maximum protection”, at the low price of N\$1.00 (approx. 0.13 CAD) for a package of four (!Goraseb, 2006). Its golden package depicts a smiling older black couple gazing into each others eyes in a loving embrace, modestly clothed and photographed from the neck up (Figure 4). In 2000, the Namibian Social Marketing Association (NaSoMa), a Windhoek-based NGO initially funded by the Ministry of

Health and Social Services (MoHSS) and now by the Republic of Germany, introduced the Cool Ryder condom, priced at between N\$1-2 for a package of six. Their goal was to reach previously neglected condom sales points such as *shebeens* and nightclubs (!Goraseb, 2006). Unlike the more conservative Maximum Gold brand, Cool Ryder's multi-coloured package portrays a minimally dressed inter-racial couple dancing seductively at a nightclub, the man's hand resting suggestively on the woman's stomach.

Figure 4: Maximum Gold package



Figure 5: Cool Ryder package



Further, the unique “dotted” design of the condom is highlighted, along with its ability to produce “heightened pleasure”, although who is to be the beneficiary of such pleasure is not clear (see Figure 5). Perhaps partly due to successful marketing, Cool Ryder is Namibia’s best-known condom brand (GITEC/NaSoMa, 2001).

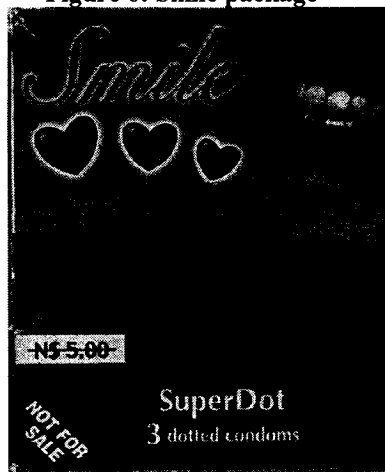
In 2003, NaSoMa widened its prophylactic offerings to include Sense, an upmarket line of strawberry, banana and mint flavoured and coloured condoms directed towards more affluent consumers, priced at N\$5.00 for a package of three.

In this new consumer landscape of internationally subsidized and branded condoms, characterized by glossy packaging, fruity flavours, bright colours and sensitivity-enhancing dots, the bare-bones government-distributed condoms reportedly began to suffer from a serious lack of interest among condom users, one that bordered on aversion. The government reported that users complained that free condoms carried an “unpleasant smell”; that the lubricant was “too sticky”; and that in some cases, the condoms were too large (!Goraseb, 2006:1). Both in response to these complaints, as well as to the propagation of other rumours questioning the safety of free condoms throughout Namibia, the government released the branded *Smile* condom in February 2006, manufactured at a plant in Windhoek to eliminate quality and exposure issues. According to !Goraseb (2006:2), the “government decided to brand its condoms and to launch a marketing strategy in order to convince the man on the street that he was using a quality product.”

The Smile condom package (Figure 6) depicts the lower half of a smiling face in the upper right corner. Below it are three red hearts hanging above the words “Bringing the Smile back to your face.” In the background, providing a marker of the product’s

“local” origins is a photo of the Namib Desert peppered with a few lush palm trees, a type of vegetation typical of north-eastern Namibia. A price of \$N5.00 is apparent in the lower corner of the package, although it has been struck through in red, the words “NOT FOR SALE” imprinted underneath. Like Cool Ryder, the condoms are “dotted”, although Smile has taken the claim of heightened sensitivity one step further by applying the label of “SuperDot.”

Figure 6: Smile package



Generalized Mistrust in Condoms

To many of the young Namibians I spoke to, condoms were not simply devices that unproblematically facilitated safer sex. Within the diversity of condoms available in Namibia, a hierarchy of perceived safety was apparent, one that was organized according to brand, price, and product origin. Young people’s estimates of condom efficacy were often much lower than those established by scientific data, and certain condom brands were perceived as producing negative effects upon the body, such as allergic reactions. While the oft-cited CDC statistic places condom efficacy at 98% in preventing pregnancy and having a breakage rate of only 2%, (CDC, 1999:4), young people instead provided

estimates between 60 and 100 percent, most of these estimates lying toward the lower end of the spectrum. While some individuals indeed stated that they thought that condoms were very effective, and thought that the people who questioned their safety were simply looking for reasons not to use them, many also believed that condoms were “not one-hundred percent”, the margin of failure being indeterminate, yet significant. There was an implicit sense that using a condom did not necessarily constitute the practice of safe sex, and condoms should generally not be trusted to work as advertised. During one focus group, a high school-aged girl stated “I don’t trust condoms – they are dangerous!” her friends nodding in agreement with her assessment. This lack of trust was encountered in subsequent discussions, and was explained to me in a number of different ways. One common belief was that condoms were permeable, covered with small “holes” that surreptitiously facilitated the passage of HIV. Young people also reported condoms untrustworthy because they felt that they were weak or poorly made, and hence susceptible to breakage. Ndiya, a young man who had recently finished university and was starting his own business, spoke with me one afternoon about his belief that condom breakage was an extremely common phenomenon that was causing an unnecessary increase in HIV infection among young people. He saw the experience of condom breakage as a demoralizing one that might make a person forego safer sexual practices in the future, because of a breach of trust and an unnecessary exposure to risk:

And what happens [when a condom breaks]? If this happens to you, you completely lose hope and then you don’t care if you use one the next time because there’s already a possibility that you’ve infected yourself.

Ndiya believed that the solution to the problem was the distribution of “good-quality” products to the population, in contrast with the “lower-quality” free condoms currently

available in hospitals and clinics. He understood the assurance of quality as being an important factor in motivating condom use: “it’s important that the condoms are of good quality if you want people to use them and trust them.”

Mistrust in Ministry Condoms

The theme of “quality” as it related to condoms was one that was often brought up by informants. While a generalized uncertainty about the efficacy of condoms appeared common, one type of condom in particular was viewed as being the least effective in preventing the transmission of HIV: the free condoms provided by the government in hospitals and clinics. The following quotes by a group of 17 to 25 year-old male and female youth illustrate a number of the common misgivings young people expressed towards government-issued prophylactics in particular:

Hospital condoms are unsafe: if something is free it isn’t as good. You must pay for quality (Nadab, Male, 25).

The worst are the free condoms. I wouldn’t advise anyone to use them unless there was nothing else (Jason, Male, 23).

There is a lot of discrimination against the free condoms given by the hospitals – people say that they are of poor quality and that they burst [break] easily. The ones from the shops are quality products (Mabel, Female, 17).

Free condoms are ok for those who have no other options, such as for those living in the rural areas or for those who cannot afford to pay for them. But everyone knows that they are of low quality and tend to burst (Rutendo, Male, 21).

Free condoms are like cheap clothes – they tear quickly (Leila, Female 19).

These statements express the commonly articulated belief among young urban Namibians that free condoms are simply not of the same quality as branded ones, despite the government’s claims to the contrary. While all condoms were perceived by youth as

being prone to breakage, it was free condoms in particular that were identified as being the most likely to break, due to their perceived lower quality. Because of this, free condoms symbolized the antithesis of safe sex – the use of free condoms was believed to be an *unsafe* activity capable of increasing one's chances of contracting HIV. For those who expressed such sentiments, putting one's trust in free condoms was described as tantamount to taking a risk that could result in one becoming infected with HIV.

Beyond facilitating the spread of HIV through latex breakage or through the small holes that were believed to cover free condoms, some young people also reported that cheaper and free condoms caused negative side effects upon the body, such as allergic reactions. During focus groups, four young women reported that they were specifically allergic to Maximum Gold, Cool Ryder, and free condoms. The same women maintained that they were not allergic to Sense condoms, the flavoured and coloured brand produced by NaSoMa, which is also incidentally the most expensive socially marketed brand on the market. This sentiment was also apparent during the observation described in the introduction, where FBO volunteers handing out Smile condoms were met with the response that individuals were “allergic to those things.”

Conspiracy beliefs about free condoms were also apparent, although they were articulated with some subtlety, usually in the form of questions rather than direct claims or statements. Many of the AIDS conspiracy beliefs in Africa documented by other researchers tend to implicate the governments of the West in the spread of the disease (Rodlach, 2006; Kaler, 2003). As such, Western researchers may find it difficult to engage in such discussions, as individuals may be reluctant to discuss such matters with an individual from the culture or country who is being accused, as Rodlach (2006)

explained. Kaler (2006) may have been able to sidestep this issue by employing local researchers, who documented conspiracy beliefs with fellow locals largely in casual social situations. The young people I interviewed may have been less inclined to share their conspiracy beliefs with me, the Western researcher. Despite this, I believe I was able to gain a sense of young people's conspiracy beliefs both through the questions they posed to me, as well as information gained by Namibians working in public health and AIDS Service Organizations, who described to me the conspiracy beliefs they encountered and addressed in their work.

The motivations of countries that provide free condoms to Namibia remained suspect to young people, as was evidenced by commonly-posed questions about why foreign countries should take such an interest in donating condoms to Namibia, and what do they stood to gain from this action. A few described beliefs held by others (although not themselves) that condoms donated by foreign countries, especially the United States, actually contained HIV; thus their distribution was an attempt to infect Africans so as to better gain control of the continent. Another reason heard by a young Namibian working in an ASO was simply the belief that "Westerners want Africans to die", and hence it is believed that condoms provide a particularly sinister and efficacious route to accomplish this task. Doubts circulating about free condoms were most often related to the idea that they were "foreign imports" from outside of Namibia, calling into question the motivations of suppliers. One government representative commented on the reasons for why young people might doubt the provision of condoms by the international community in Namibia, specifically the provision of condoms by the United States Agency for International Development (USAID), whose name and function was explained to me as

being perceived by some as indicative of US government involvement in spreading HIV/AIDS across sub-Saharan Africa (US-AIDS). She explains this belief further:

I think some of the reasons were political – people think strange things. For example, we once had a [condom] donation from USAID and people didn't trust it because it was coming from the USA...they had these ideas that AIDS came from the US and that the plan was to infect Africans. We had to go in and try to convince them that they were ok – but it's not easy... people always think that when something is coming from somewhere else it's a reason not to trust it.

The lubricant used on free condoms may have also been perceived as a vehicle for the transmission of HIV: some young people were curious about what it contained, and why it had such a strange texture. Some also expressed curiosity about how long HIV could survive outside the body, and asked if it could survive for long periods of time if kept in a liquid vessel, perhaps viewing condom lubricant as one possible vessel for HIV transmission. Similar views about the trustworthiness of imported health products were expressed about the polio vaccine used to counter an outbreak that took place in Namibia in the summer of 2006. The UNICEF-imported polio vaccine was also the source of rumours that questioned whether or not it would in fact cause polio, HIV, or both. Similarly, media reports described the polio strain that triggered the outbreak as a “wild-type” believed to have been “imported” from outside Namibia (Maletsky, 2006a). Despite such suspicions, turnout for the first round of the compulsory vaccination campaign by the government was initially high, with the government reporting 102% national coverage (Maletsky, 2006b). However, one public health expert involved in the implementation of the polio campaign explained why she saw this high turnout as being atypical for a public health campaign in Namibia:

Blacks tend to distrust public health initiatives for diseases that seem to only affect them. But with polio the situation was different. It was

fortunate...well, I shouldn't say fortunate...but the first person to die of polio in Namibia during the outbreak was a white man. And so the people began to see that it was something really serious, not just another plot against blacks. I think the polio epidemic really brought us together as a nation, it really showed that such diseases can strike anyone.

In addition to the notion that health products and diseases coming from outside of Namibia are here thought about in conspiratorial terms, there is also the perception that the targets of such initiatives and diseases are largely black. In this sense, rumours and anxieties about condoms in Namibia share much in common with similar rumours in circulation in other parts of Africa.

Just Smile?

While free condoms may give off an aura of lowered quality due to their simple packaging and lack of dots or colours, one would assume that the government's new packaged, branded, yet free-of-charge *Smile* condom would be meeting some success in changing people's opinions about the relationship between price and value. However, attitudes toward *Smile* shared much in common with those directed towards free condoms, as the quotes by a group of males and females between the ages of 16 and 24 below illustrate:

I haven't tried *Smile*. They look nice, but I don't think they have quality. They have spaces [holes] in them (Renata, Female, 16).

Smile condoms are free, so they are cheap. They burst easily. Others say no, they are good. I don't know (Georgia, Female, 18).

Smile are still Ministry condoms...I would rather buy my own. It's a matter of quality, it should be something worthwhile (Felipe, Male, 21).

Even these *Smile* condoms, I've heard things about them, that they're not strong...(Matata, Male, 24).

I find them to be just the same as the hospital condoms, they're just the same, they have the same characteristics. That's why they're free, just

to make people aware. They're low budget condoms for the economy. They're low quality – I think they're Namibian-produced. The other types of condoms are not Namibian – like Sense – they're made in South Africa. But Cool Ryder, I'm not sure where they're made (Abidemi, Male, 23).

The above quotes illustrate that the government's efforts to provide a branded, packaged product that aimed to highlight the pleasurable aspects of its use, as worked so well for Cool Ryder, may not have been met with the expected success among young people. "Ministry" products seemed to be tainted, viewed as low quality no matter in what form they were made available. Young people explained these ideas about quality in terms of their doubts that the government was doing its job when it came to safety and permeability standards. Awa was a young high school aged girl whose mother was a nurse and often bought condoms for her. While trusting the socially marketed brands she used, she seemed to doubt the government's products: "I don't think they [the government] are testing everything like...microscopically. How do they know that they [condoms] don't have holes?" Another common idea that had begun to take hold about *Smile* condoms was that the condoms were good for slow, gentle sex, but in "rougher" situations they were more likely to burst. Such beliefs were also heard among adults. One sex educator described to me how he would often blow up condoms and rub them with Vaseline to demonstrate to young people that oil-based lubricants should not be used with condoms because oils break down latex. The loud "pop" of the condom is usually an effective sensory strategy that remains with the audience, helping them to remember not to use such lubricants with condoms. He explained that he usually performed this demonstration with hospital condoms, but decided to try *Smile* once:

A few weeks ago I did a demonstration with this new *Smile* condom that the government has come out with, and the thing

burst as soon as I blew it up! That has never happened with any of the free condoms, they seemed more durable somehow. I think that this new 'dotted' design thing is negatively affecting the strength of the condom somehow.

Branded Condoms

In contrast to the aversion towards free condoms, many young people identified Cool Ryder condoms as the most popular and trustworthy brand. Young people often explained their positive feelings towards the brand in part because of its claim of being able to produce "heightened pleasure" due to its dotted design. A second reason young people explained they trusted it was because it was produced in Namibia. As one young man stated, "Cool Ryder is a good brand, they're strong – I ride cool! I trust those ones; they're Namibian-made." NaSoMa staff often emphasized the local origins of their product, describing it as the country's only truly Namibian condom. Other young people felt that Cool Ryder's higher quality was due to the fact that it was imported, as one young male university student stated: "Cool Ryder is better because it's imported...I think it's a German manufacturer who makes them."

Sense condoms, also produced by NaSoMa, were consistently identified as a favourite brand among young people, many of whom would spontaneously sing out the advertising jingle that described the condoms' banana, strawberry, and mint flavourings. I would often bring a variety of condoms to focus groups for demonstrations; participants most often asked if they could take home Sense condoms over all the other brands. They were consistently identified as one of the best, highest quality brands, and well-liked because of their bright colours and interesting flavours.

Testing Condoms

Another indication of the mistrust in condoms is apparent in the practice of “testing” condoms, as was described to me by several young people. Scholastika Ipinge, in her 2004 study on the relationship between gender roles and HIV infection in Namibia, reported that the phenomenon of young men conducting experiments to test the efficacy of condoms was quite common, mostly among those who “are convinced that condoms from the health facilities have holes and are likely to spread the HIV infection instead of preventing it” (Ipinge 2004:33). This phenomenon became apparent to me through a discussion I had in 2004 with Jonas, a young student from northern Namibia now residing in Windhoek. Jonas was extremely sceptical about the efficacy of condoms, and had conducted extensive experiments upon them, attempting to prove that the latex barrier was permeable due to the small “holes” that he believed covered the surfaces of all condoms. He related one such experiment to me one day: He placed three condoms filled with an iodine/water mixture representing seminal fluids in three test glass beakers filled with a starch/water solution representing vaginal fluids. He explained how he heated one beaker to 37 degrees Celsius, another to 74 degrees Celsius (representing the combination of the body temperatures of two people), and the final one to 85 to 90 degrees Celsius, apparently to account for the extra heat generated by friction during intercourse. As fluids from the “female side” had permeated the latex barrier in the two beakers heated to higher temperatures, Jonas saw this as concrete evidence that condoms were permeable to HIV. Further, according to his results, he concluded that a woman could transmit HIV to a man during protected sexual intercourse, but not vice versa. He explained that people would often ask him if he worked for a condom company, due to his serious interest in condoms.

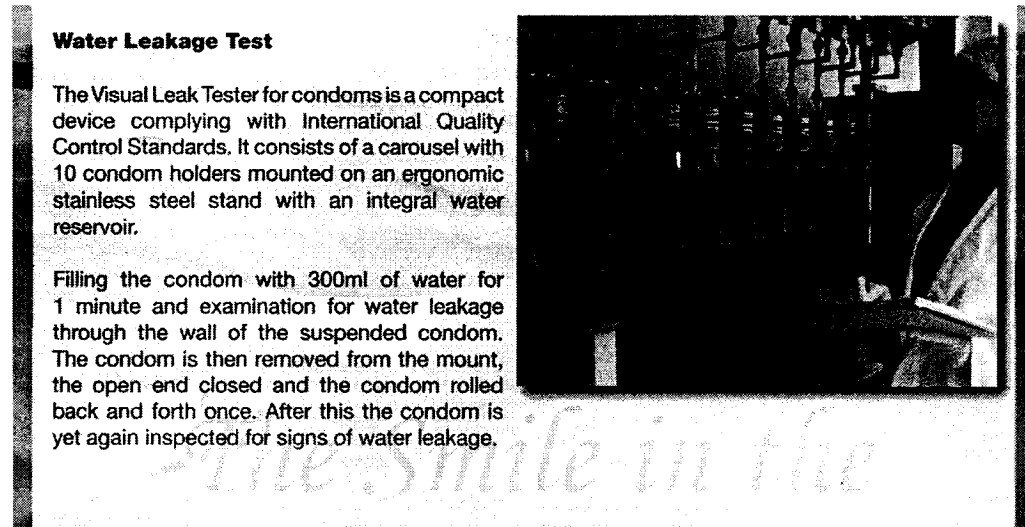
During focus groups, young men similarly revealed that they would often devise experiments to test the durability and strength of condoms, using the results of such tests to determine which brands were the most trustworthy. One simple test was to blow up a few varieties of condoms like balloons and observe which ones deflated the most quickly. The condoms that suffered the most amount of deflation were identified as the least trustworthy, and this was perceived of as tangible evidence of the small “holes” that allowed the passage of HIV through condoms. Alfonso, an economics student at UNAM, also reported conducting a variation of such a test, although to him it was Cool Ryders that proved to be less durable:

One day I filled up the two different kinds of condoms with water, the Cool Ryders and the free ones. So I found that the free condom really held the water for a very long time and I had to struggle to break it! But the Cool Ryder condom burst quite quickly. So I find that Cool Ryders are not very strong, I think the hospital condoms are actually better.

Possibly in response to such widespread doubts, government agencies countered, via their own depictions of scientific tests, that condoms, in particular the new Smile brand being produced by the government, were indeed highly effective and trustworthy. In a booklet entitled *The Smile in the Desert*, the company responsible for the production of the Smile condom presents a visual tour of its quality control procedures through a number of vignettes. The photos and the accompanying texts depict and describe the seven ways in which condoms are tested for defects, presumably attempting to address some of the popular concerns about condoms that have led to individuals conducting “unscientific” tests on condoms. The tests depicted, although considerably more complex, share much in common with the popular tests conducted by young people. The photos depict serious scientists undertaking condom experiments using sophisticated machinery (see Figures 7-

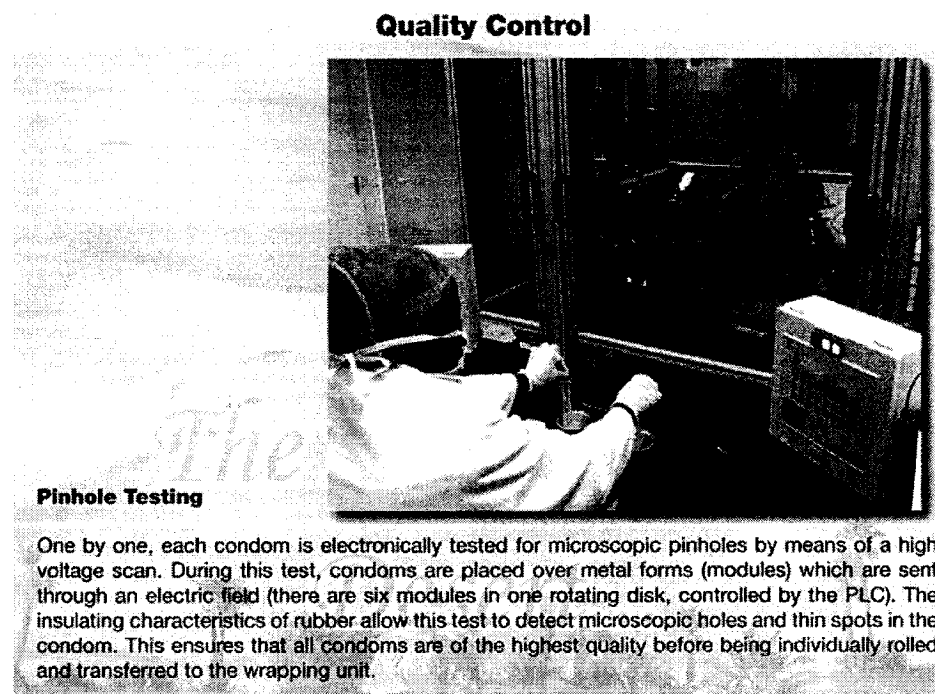
8) and seek to bolster claims of safety by highlighting the company's adherence to international WHO standards.

Figure 7: Smile Water Leakage Test



Source: "The Smile in the Desert" pamphlet. 2006. Commodity Exchange, Windhoek.

Figure 8: Smile Pinhole Testing



Source: "The Smile in the Desert" pamphlet. 2006. Commodity Exchange, Windhoek.

Discussion

Are there any material reasons for why young people should express such doubts in the efficacy and safety of condoms, to the point that they would be motivated to test them themselves? The sole recorded event that called into question the safety of free condoms is found in a 1999 article in the widely-read national daily newspaper *The Namibian*, which reported that expired condoms of an unknown country of origin were being distributed at certain hospitals and clinics in and around Windhoek. Despite NACP's vow to destroy the affected condoms, the newspaper reported that expired condoms were still being found in hospitals, due to understaffing (Amupadhi, 1999). While this event could have been the solitary spark that has ignited the lack of trust in free condoms in urban Windhoek, I would like to explore some further material and symbolic reasons for why young people may express such doubts, placing their claims within the wider social contexts in which they circulate.

What is apparent in the statements made by youth is that they strongly associate the notion of "quality" with high-priced condoms, generally obtained through social marketing organizations. Such condoms were explained as preferable largely because they were viewed as being "safer." Leila, the young Namibian fashionista above drew on her experiences with price and quality with other private sector commodities in explaining why she doesn't use government condoms: "free condoms are like cheap clothing - they tear quickly." Such a relationship between quality and safety may not only be related to price, but also to advertising and packaging: while the manufacturers of condoms in "the shops" successfully make widely advertised claims about their quality and their ability to create heightened levels of pleasure and display their condoms in

attractive packages, the government does not, having until *Smile* neglected to develop a campaign that promoted the safety of free condoms.

One attempt to counteract the negative perceptions surrounding government-provided health products and services is the strategy of attaching a “price tag” to *Smile* condoms, in an effort to re-brand them as private sector commodities, even though the condoms are distributed free of charge. Another is their advertising tagline, “The Best things in Life are Not for Sale”, which attempts to reframe the traditional relationship between price and perceived value. Despite these actions, *Smile* condoms were also mistrusted, presumably because they were still identified as “Ministry Condoms” – condoms whose reputation and efficacy were already compromised because of their association with the government. Thus, in making the decision to use a product that ultimately stands between good health and disease, young people refer to price and the private sector origins of a condom as indicators of quality, and hence of the expected level of safety.

Because of this, condom use as an expression of conspicuous consumption seemed to be apparent. The quotes above illustrate that free condoms are associated with a number of negative material and symbolic characteristics, such as holes, easy breakage, and associations with poverty. Users of free condoms were believed to be economically marginalized with no other recourse to quality products – they were too poor to afford store-bought condoms, or they lived in rural areas where such products are generally unavailable. Hence, the ability to purchase and use expensive condoms may not only be a safety measure, but may also involve considerations of status and may act as a way of accessing a consumer-focused “sexual modernity” (Nguyen, 2005). This may be further

observed in the claims of allergic reactions that surround free condoms, but not the higher priced branded ones: given the widespread negative feelings associated with free condoms, it is likely that a greater sense of trust and a stronger expression of status are associated with more expensive condoms, the claim of allergies being one way of circumventing the use of cheaper products with partners.

Certain lived experiences with the public health care system, such as the one related in the newspaper report above, may have also caused citizens to lose trust in their government's ability to provide reliable health care products. Such a lack of trust is apparent in other rumours about the health care system that were encountered throughout my research, such as the rumour about a nurse in a western coastal town who was believed to have secretly infected hundreds of people with HIV, as was related to me by one young high school-aged boy:

There was this nurse in Swakopmund in the 1990s who was HIV positive and she was just injecting patients with HIV in the hospital until she was caught...then she killed herself.

While this rumour was related to me a few times in discussions with young people, it has existed at least as far back as 1999. In March of that year, *The Namibian* reported that widespread belief in this rumour caused fear-stricken residents of Walvis Bay to avoid family planning clinics in large numbers, motivating the Namibian government to publicly deny the nurse's existence, and to even seek testimony from the clergyman who was purported to have received the nurse's confession (Burling, 1999). Young people often related stories to me about the low quality of care that was to be expected in public hospitals; many of those who I knew who would visit inpatient friends or family members went so far as to bring them fully prepared meals to avoid them becoming more

sick from what they believed was extremely low quality hospital food. As Mufune's (2005) research on condom rumours suggested, rural Namibians saw the vastly underfunded and inefficient public health care system in negative terms as compared to the private system, and hence expressed a lack of trust of the quality of the condoms emerging from this sector. Thus, "rumours" also seem to find their roots in contemporary realities, rather than being simply mere inventions.

However, free condoms are not only viewed as emerging from a public sector that is unable to provide products that meet the standards of the free market. They are also implicated within global systems of trade and international development, which seem to have imbued them with additional layers of signification for young people. The precise origins of free condoms seem difficult to establish. Some government representatives explained to me that free condoms were in fact donations from a variety other countries, provided under the umbrella of "development aid" to Namibia. These condoms were described as being of variable quality due to differences in manufacturing and transport standards. However, promoters and distributors of condoms objected to such a representation of free condoms. Galina, a Namibian social marketing executive, argued that there was no substantial difference in quality between free and branded condoms, commenting that "people feel that condoms are cheap because they are free, when in fact they are exactly the same as the branded ones." Adeola, another young Namibian working at a local ASO, commented that the free condoms and the socially marketed ones were both of the same quality, now both produced in South Africa according to the same standards. Mufune (2005:684) also reports that, according to government officials, all condoms arrive in the same batch in Namibia and are then "separated out for social

marketing and free distribution.” In contrast to these accounts, one government representative I spoke to described the origins of free condoms in different terms, expressing reservations about their quality:

In the past, the previous free condoms, most of them were not of the same quality – they were coming from different countries, they had unattractive packaging. The standards just weren’t the same...people had general complaints – that they would break, that they weren’t tested, and so on.

Two types of free condoms I encountered had come from USAID and were produced in the United States, and Take Control, a Namibian organization, although the condoms were produced in South Korea, as the package was marked. It therefore seems probable that there were or may still be some real quality differences responsible for young people’s mistrust in free condoms, despite condom promoters’ assertions that all condoms are the same. This issue, combined with the perceived “foreign” origins of the devices, has provided an ideal terrain for the generation of conspiracy theories and rumours, which seeks to identify a foreign entity to blame for the continued spread of HIV in Namibia, while at the same time shaping strategic health-seeking and disease-avoidance behaviours.

The inverse of this process is seen in the valorization of “Namibian” products by informants, such as Cool Ryder and Sense, perceived to be of a higher quality and hence a safer bet. Because these brands emerged from the private sector, they were already imbued with positive associations. However, in addition, the brands profited from their status as goods produced *locally*, in Namibia. Interestingly, however, closer discussions with NaSoMa staff revealed that while Cool Ryder’s packaging was designed in and is produced in Namibia, the condoms themselves are manufactured in a factory in

Hyderabad, India, as is clearly printed on the shipping boxes (but not individual packages) of all Cool Ryder condoms. Nonetheless, it is in part the *perception* that Cool Ryder and Sense are “Namibian products” that seems to generate further trust in these brands, which lack the negative attributes associated with condoms believed to be supplied by foreigners through the government. The imagery on the Smile condom seems to mimic this association between localness and trust, as it highlights typically Namibian scenery on its packaging and accompanying descriptive text.

However, I do not wish to argue that governments should forsake public health interventions and leave them to the private market. Successful government-led health interventions have been recorded; for example, those which take trust as a starting point may be met with different community responses. Homa Hoodfar’s (1995) research on family planning policy in Iran provides an interesting contrast to the Namibian case in this regard. The goal of Iran’s family planning program, launched in 1967, was to reduce the population growth rate to 1 percent within twenty years. To this end, the Ministry of Public Health provided mostly oral contraceptives to the public, who, especially in the urban areas, were receptive to the initiative. Following the revolution in 1979, conservative leaders denounced contraceptives as devices “developed by Western powers in order to subjugate the oppressed nations and limit the number of Muslims” (1995:108). As a result, family planning clinics were closed and contraceptives became difficult to obtain. The population boom that followed caused the government to revise their position, and in 1989 a new national birth control policy was formulated, one which “convinced the population to both accept and practice family planning through a powerful consensus-building campaign and by putting in place an effective service

network to provide affordable and reliable contraceptive means” (1995:109). Further, the government presented family planning as a necessity placed in the context of the consequences of global population growth, the implications of national population growth on the provision of education and health care, and the necessity of a low population in Iran to ensuring its continued development. Even in the absence of product branding, health surveys nonetheless reported that 96.7 percent of Iranian women supported family planning (Hoodfar 1995:114).

Summary and Conclusion

This chapter presented ethnographic data from interviews and focus groups with young Namibians who expressed doubts about the safety of condom use as constituting the practice of “safe sex.” The young people interviewed expressed a generalized mistrust in the safety of condoms for the purpose of HIV prevention, although this mistrust was more often directed towards the free unbranded condoms and the free Smile condoms that are provided by foreign countries and distributed by the Ministry of Health and Social Services (MoHSS). MoHSS condoms were perceived as being of low quality, likely to break or tear, being covered with small holes, and hence highly likely to spread HIV rather than to prevent its transmission. In contrast, branded condoms such as Cool Ryder were described as being a safer option, both for the reason that they were paid for, and that they were believed to be produced in Namibia. Young people confirmed their mistrust in condoms by undertaking certain tests to confirm their durability, either by filling them with air or water and then by measuring the amount of leakage that occurred.

In conclusion, the attitudes towards free condoms expressed by young people indicate that the government’s efforts towards providing Namibians with free and trustworthy products has not been met with the expected level of success. This can be

understood in two related ways: First, young people associate the notion of quality, and hence safety, with branded products emerging from the private sector. Condom choice and use can be seen as a sort of conspicuous consumption, one that allows users to also feel as though they are making a choice and a purchase that will better protect their health. Second, mistrust in the quality of free condoms seems to be associated with young people's suspicion of the capacity of the government, and by extension, foreign governments and NGOs, to provide high-quality health products to Namibians. The government's distribution of non-standardized condoms donated by other countries seems to have been instrumental in generating widespread suspicion among young people. In a country where the origin of AIDS remained debated until recently even in the political sphere¹¹ and generalized suspicions literally and metaphorically implicate the West in the spread of HIV/AIDS, the strategy of distributing free foreign condoms may have backfired as an HIV prevention strategy. In contrast, products which emphasized their "localness" were met with a higher level of trust, and seemed more likely to be used.

What also must be considered in this analysis is the ways in which other actors may actively seek to undermine public health efforts by challenging dominant biomedical knowledge. The questions about condom efficacy posed by young people are also shared by one other group in Namibia: Pentecostal religious leaders. This group seeks to convince Namibians that condoms are much less effective than popularly believed, mainly through the presentation of scientific data that calls condom efficacy into

¹¹ In 2001, former president of Namibia, Sam Nujoma, publicly blamed the origin of HIV/AIDS on an American biological warfare initiative gone wrong. Nujoma stated that the US government had developed the virus during the Vietnam war as a part of a biological warfare program. They then "tested some of it on homosexuals, some of whom slept with women." Nujoma asserted that the information proving that AIDS was a manmade affliction was being kept quiet, although it had recently been uncovered by a French scientist (Menges, 2001).

question. The next chapter explores the nature and transmission of such discourses, arguing that they further contribute to the climate of suspicion about condoms apparent in Windhoek.

CHAPTER 4: FAITH IN GOD, FAITH IN CONDOMS: CHURCHES AND COMPETING VISIONS OF HIV PREVENTION

Will condoms prevent the spread of HIV/AIDS?

No! The condom is riddled with microscopic or larger holes natural in manufacture. The smallest hole found in condoms is two to ten times larger than the AIDS virus. Condoms have not, will not, and cannot prevent AIDS!

Poster entitled *The Shocking True Facts about AIDS: The Most Heinous Crime Man has Ever Perpetuated Against Its Own kind!*

In the midst of the HIV/AIDS epidemic, Christian churches in Namibia have emerged as significant sources of authority both shaping and executing HIV prevention and care initiatives, reaching into “remote” locations where they are often the sole providers of community services. Churches and faith-based organizations occupy a critical position in the fight against HIV, comprising one in five organizations engaged in AIDS programming worldwide (WHO, 2004). While the Namibian government has aimed to promote the use of condoms as a way for sexually active Namibians to engage in “safe sex”, this action has been challenged not only by young people, as described in the previous chapter, but also by certain religious leaders. This chapter explores the ways in which these religious leaders depart from dominant public health conceptions of condom use as facilitating safe sex. Instead, to many of them, condom use is constructed as its antithesis.

I begin by grounding this local phenomenon within a larger global movement apparent among religious groups, who have begun to engage with the uncertainties of science to contest dominant public health knowledge in their efforts to justify Christian-based HIV prevention strategies. I argue that when religious leaders use science and conspiracy to challenge the efficacy of condoms, they tap into the existing uncertainties about condoms already in circulation among young people. In so doing, they are also able

to promote abstinence and faithfulness as the only truly “safe” ways to prevent HIV infection.

I would like to draw upon Emily Martin’s (1998) conceptions of scientific knowledge as being linked with processes and events occurring “out there” within society, rather than being confined to the domain of science. Martin argues that scientific knowledge does not flow out to society in a unidirectional way; rather, nonscientists interact with scientific knowledge to make use of it in ways that their originators had not intended, either by appropriating and reinterpreting scientific ideas and materials, or even by altering the agendas of researchers. This ethnographic data points to such an engagement with science, where pastors take advantage of the gaps created by scientific uncertainty to give weight to faith-based arguments about sexual morality.

Doubting Condoms Internationally

Questions, rumours and doubts about the efficacy of condoms appear to be a global phenomenon, having gained currency among conspiracy theorists, HIV/AIDS-affected communities, and religious organizations as a way to explain the perpetuation of epidemics of HIV/AIDS (Kaler, 2003; Pfeiffer, 2004; Rodlach, 2006; Stadler, 2003; Willms et al., 2004). Among these discourses, the use of scientific language and research to argue that condoms are ineffective against the spread of HIV one specific form that was apparent among religious leaders in Namibia.

Religious groups worldwide have recently begun to adopt the language of science in discussions surrounding condom use in contexts of HIV/AIDS. One well-developed example is found in the article *Family Values vs. Safe Sex*, by Catholic Cardinal and president of the Pontifical Council for the Family, Alfonso López Trujillo (2003). There, a litany of scientific evidence is cited supporting the claim that condoms are much less

effective than popularly believed to be: hence, the devices are understood as being irresponsibly promoted by governments and international health agencies. These groups are conspiratorially accused of using science to further “certain economic interests on the part of condom producers, with an ‘ideology’ of the powerful against the poor in line with ‘population control’” (2003: sec. 4). Trujillo rejects a secularist construction of the Church as a monolithic organization that “contributes to the death of millions by not promoting or allowing the use of condoms in the fight against the pandemic” (sec. 18). Rather, he directs the finger of blame towards those who promote condoms “without properly informing the public of its failure rates...that have led to, lead to, and will continue to lead to the death of many” (sec. 18). Trujillo further asks

...why, despite the invitation to promiscuity made by the “safe sex” campaign and the distribution of an enormous quantity of prophylactics where the pandemic is more widespread, the problem of infection has become even greater (2003: para. 11).

What is interesting is that Trujillo’s opposition to condoms does not rest solely on the morally grounded argument that condoms prevent contraception and hence interfere with the “natural” course of reproduction. Rather, his argument centres upon challenging the generally accepted scientific wisdom that presents condom use as an effective way to prevent of pregnancy, STDs, and HIV. Further, it questions the hegemonic role of the state and international development agencies in family planning, seen here as underhandedly pursuing a form of unwanted population control.

Such international debates have also resonated on the local level among religious organizations, especially at the epicentre of the epidemic in Southern Africa. South African Cardinal Wilfred Napier recently echoed Trujillo’s sentiments, asking:

Can you show me one example where condoms have stopped the spread of AIDS? If you look at South Africa, millions have been spent promoting condoms and we have one of the highest rates in the world. By promoting condoms we are promoting immoral behaviour (Napier in Goodman, 2005:para 3).

Elsewhere in Southern Africa, the Catholic Bishops of South Africa, Swaziland and Botswana have put forth a joint statement advising against the use of condoms as a means to stall the spread of HIV. In an article published in Greenhaven's *Opposing Viewpoints* series, two of the four reasons the Bishops cite for their opposition to the promotion of condoms are that they "...do not guarantee protection against HIV/AIDS", and somewhat more conspiratorially, that they "may even be one of the main reasons for the spread of HIV/AIDS" (Catholic Bishops of Southern Africa 2005:76). Supporting this claim is data from a study that determined the failure rate of condoms to be "up to 30 percent", according to the Catholic pro-life organization listed as the study's author, Human Life International, whose stated mission is "to fight the evils of abortion, contraception, sex education and family breakdown." The organization further declares, without elaboration, that were it not for the existence of HLI, "whole continents, like Africa, would be left virtually defenceless against the culture of death" (HLI 2007:para 2).

While these examples indicate an opposition and suspicion towards condoms, presented through a scientific idiom, I do not wish to homogenize religious groups internationally or in Namibia as unequivocally holding similar views. In 2001, The World Council of Churches questioned the widespread religious resistance to the recognition of condom use as a reliable method of HIV prevention, asking: "should not the churches, in light of [scientific] facts, recognize the use of condoms as a method of prevention of HIV?" (WCC 2001:62). Likewise, in Namibia, the Evangelical Lutheran Church has

adopted what it calls the ABCD strategy, which sets up a hierarchy of HIV prevention behaviours. As Lutheran pastor P.J. Isaak explains, to be abstinent and faithful is “the Christian way, and it guarantees LIFE. But if you find that you cannot follow this teaching, then choose C for a condom, because the alternative is D for death.” (Isaak 2000:114) Other groups, such as the Catholic Church in Namibia, are ambiguous about their stance on condom use, although the largest AIDS service organization in Namibia, Catholic AIDS Action, has also adopted the ABCD principle. It has also successfully built partnerships with NGOs that produce and promote condoms, such as the Washington-based Social Marketing Association (SMA). Further, members of several FBOs and churches in Namibia mentioned that they did discuss condom use and even sometimes distributed the devices secretly, despite organizational constraints and prohibitions. Other “middle way” approaches include those emerging from the Council of Churches in Namibia, who in a 2001 Pastoral Letter on HIV/AIDS chose to avoid the question of condoms altogether, stating only that it encouraged “abstinence and the empowerment to say ‘No’ to unwanted sex” (CCN, 2001). Standing in contrast to these approaches are Pentecostal groups in Namibia. Such groups actively preached about the inefficacy of condoms in preventing HIV, using the media and political channels as a means of spreading this message beyond the pulpit.

It is obvious that a diversity of opinions on the role of condom promotion in HIV prevention exist among religious groups in Namibia, and that a direct association cannot be drawn between churches and anti-condom views. Despite the contestation over condoms, churches and their organizations in Namibia are generally highly involved in HIV prevention and outreach, seeing these actions as vital components of their ministries.

All churches surveyed were in some way or another involved, although their activities tended to lean more towards outreach than prevention. Churches and FBOs reported taking care of orphans and vulnerable children affected by the epidemic, gathering funds for funerals, providing economic and emotional support (income-generating activities, counselling), and taking part in and directing home-based care activities for the infected. Larger FBOs also run hospitals and clinics, ante-natal testing programs, and Voluntary Testing and Counselling (VCT) centres. Spiritual and bodily healing of HIV/AIDS was a component of the care activities of mainly Pentecostal churches, with one church having made plans to build a large centre in Katutura devoted solely to this task. In addition, it should also be noted that churches and FBOs tend to provide services to the broader community, rather than just to the members of their congregations or religious denominations.

Doubting Condoms in Namibia

The global debates emerging from the Christian groups described above that question the efficacy of condoms in the prevention of HIV were also manifested locally among religious leaders, most often among those associated with Pentecostal churches. What was common among nearly all religious leaders interviewed was that they expressed serious doubts about the efficacy of condoms in protecting against the transmission of HIV, largely choosing to preach against them and the public health messages that promoted their use. The sole justification for condom use identified by informants involved cases of sero-discordant couples, where one partner is HIV positive, the other negative. This was due to the belief that both divorce and the possibility of infecting the other partner with HIV were considered to be graver transgressions when compared with condom use.

In many respects the beliefs about condoms held by religious leaders were similar to those described by youth in the previous chapter: they also perceived condoms as being ineffective, or at least not “one-hundred percent” safe, and hence, were believed to be capable of infecting an individual with HIV. Interestingly, the argument that condom use should be foregone because of religico-moral considerations was not often deployed. Rather, religious leaders took a distinctly scientific approach in their claims against condom use, citing scientific studies, reports, medical opinions, and anecdotal evidence to further the claim that the devices were not as safe as people have been led to believe. I met Pastor Ezekiel, the founder of the Jesus Saves Pentecostal church, close to the end of my stay in Windhoek. His church was particularly active in HIV prevention and care activities, running AIDS orphan feeding schemes, home-based care, and care of HIV positive women with children. He was a vocal supporter of abstinence and faithfulness, and often used scientific language and research to back up this position. Pastor Ezekiel explained his opposition to condoms in the following terms:

We’re against condoms because 15% don’t work...15% of condoms worldwide are not effective. And actually we’ve got statistics from Kenya, Cameroon, and some other countries: the more condoms that were sold, the higher HIV rate, the less condoms sold, the less HIV. We have thirty nine international scientists and investigators...look at the articles.

Some religious leaders also explained that contraceptives in general were proscribed by many churches because they prevented pregnancy, and hence interfered with the “normal” course of reproduction. However, it was often the language of science that was used to support and strengthen this primarily moral argument. A South African priest from a medium sized church in Katutura combined these two rationales in putting forward his argument against the use of condoms:

[The Church] says ‘no’ to condoms – they are not meant for AIDS prevention. Many people also got HIV through using condoms because they burst, and because they have tiny holes in them – they are not 100%. So the church says no. The condom is a contraceptive – it interferes with the creation of God, the normal way, in the sense that when we have sex the normal result is pregnancy [emphasis added].

Similar to the beliefs of young people, the low rates of condom efficacy cited were most often explained by the idea that male latex condoms were highly permeable, both to sperm and HIV, because their surfaces are believed to be riddled with “pores” or small holes that would allow the escape of the virus. Religious leaders often reasoned that because the HIV molecule was smaller in size than sperm it was better able to exploit this permeability, able to escape through the condom and infect unsuspecting users. I met Matteus, a middle-aged Baptist sexual health educator who gave Christian-themed sexual health presentations to mainly Pentecostal youth, through a friend at a Pentecostal Church. He was extremely well-versed in the international HIV/AIDS literature, citing peer-reviewed papers, Johns Hopkins reports, newspaper articles, and any other type of information he had found that supported the claim that condoms were ineffective, and that abstinence and faithfulness were the sole actions proven to decrease the prevalence of HIV. Latex permeability was one concept that he used to explain condom inefficacy:

Condoms do fail – they are not infallible. There are pregnancies that are reported, even with the use of a condom. And for that to happen, *it’s a requirement that sperm escapes from the condom – for HIV that opening can be even smaller* [emphasis added].

Pastor Joel, a charismatic HIV healer from the Hand of God church whom I met at one of his healing sermons, didn’t necessarily have access to the studies cited by the above speakers, who were educated and held relatively high positions in their churches, but nonetheless had adopted these theories in his own descriptions of condom inefficacy.

Pastor Joel describes below what he had learned at a recent faith retreat on HIV prevention for Pentecostal pastors:

...according to what the scientists and doctors told us, when you look at a condom, there is a small hole in the condom, so people are not so safe. It doesn't matter what kind of condom they use, be it chocolate, be it strawberry, be it any kind of stock.

Religious leaders also constructed condoms as fallible objects created by fallible humans, who erroneously believed they had engineered a way to protect themselves from HIV, a virus infinitely more capable of bypassing such defences. HIV was depicted as a sneaky virus, one intelligent enough to evade condoms and other human-created defences designed to counteract its spread. The virus is ascribed human qualities, such as a "brain", and is seen as capable of hiding itself and attacking from within. Pastor Brown, a young Pentecostal preacher at the Jesus Saves church engaged with scientific knowledge to prove his point below:

...the HIV/AIDS virus *can penetrate through the pores of a condom*. Condoms say, "store in a cool place." It's not cool while you're having sex, things expand. This HIV/AIDS virus has a brain of its own; all [other] viruses you can study and say, after so many weeks and months, this and this and this will happen. With HIV you can't. This virus has got a brain of its own; it decides when to attack, where to attack and then it hides itself in human tissues [emphasis added].

Justified by the belief in condom inefficacy, the argument that condom promotion itself was to blame for rising rates of HIV infection across Africa was commonly made by religious leaders. This argument was seen by some in more conspiratorial terms, and implicated governments and international aid agencies in facilitating HIV's continual spread. These agencies were blamed for the spread of HIV for a number of reasons: some blamed them and the foreigners they employed for creating the demand for the sex trade that they believed motivated women to engage in sex work. Others blamed them for

continuing to promote the condom as a solution to the epidemic, even though they were perceived as being unsafe. As Pastor Ezekiel explained his reservations:

Since it's a scientific fact that fifteen to twenty percent of condoms are not safe, and eighty percent are safe, and the condoms in Africa are being sponsored by the United Nations, the question comes then if they are not purposely trying to eliminate the populations of Africa. Some people think it's far fetched...but why an organization like United Nations, with their health organization [WHO], would sponsor distributing of millions of condoms, knowing that only eighty percent work, and knowing that those who get HIV/AIDS are going to die.

Dr. Eva Seobi, a member of the Christian health organization Doctors for Life South Africa, and a vocal abstinence campaigner in Namibia echoed these conspiratorial views, albeit in a more ambiguous manner. In a recent media interview, she provides her opinion on the causes of the high rates of AIDS prevalence in South Africa:

...Condoms, as far as I am concerned, they are not one hundred percent protective. So they can't protect and so they can't even prevent the transference of infection from one partner to the next. The more that they campaign on condom awareness, [...] not just AIDS awareness, but condom awareness, and as far as the campaign goes up, the rate of AIDS infection also goes up. That, to me, means one of two things: either people don't know how to use the condom, or *people use the condom with an understanding that the condoms are going to protect them, whereas they don't* (Seobi, 2006, emphasis added).

Seobi thus attributes the rise in HIV infections to the rise in condom promotion campaigns, related either to user error, or, more ambiguously, to the possibility that condoms do not actually protect people, although she does not elaborate on the reasons for why this may be so. In this sense, instead of being viewed as instrumental partners in the fight against HIV/AIDS, governments and international aid agencies are perceived to be colluding with unidentified forces to contribute to the increase of infection among citizens through the promotion of condoms.

The above data points to an engagement with science on the part of religious leaders in an effort to better convince congregation members, and perhaps the public at large, that condoms are not effective in preventing against HIV, while abstinence and faithfulness are. In an effort to lend strength to this argument, religious leaders pointed to one country in particular that provided a “scientifically-proven” exemplar where a perceived focus on abstinence and marriage, and a shift away from condoms had led to a decrease in the rates of HIV infection. This country was Uganda.

Uganda as Exemplar

The rising rates of HIV infection in Namibia were often explained by religious leaders as being partly the result of the promotion of condoms as a solution to what they saw as the larger problem of casual sex. Such practices were seen as contributing to the rise in HIV infection across Africa, and could only be solved by recognizing that the promotion of condoms had to be forsaken in favour of the promotion of abstinence and faithfulness. Religious leaders engaged with the scientific evidence surrounding one example to prove this belief: Uganda’s solitary success among sub-Saharan African states in dramatically lowering its levels of HIV infection. In this sense, Uganda was constructed as an exemplar of what abstinence-based, Christian-directed programs could accomplish with regard to stalling the spread of HIV.

Exactly how Uganda was able to reduce the incidence and prevalence of HIV infection from a high of 36% in some urban sites (with the national average at 21%) in 1991 to 8.3% in 1999, and down to 5% in 2001 (Cohen, 2002; Parikh, 2005) remains a contentious issue – one popularly held belief is that it was Uganda’s adoption of the ABC approach that was responsible, one that has been widely exported across Southern Africa, Namibia included. This is due to the promotion and support of the ABC approach by

organizations that devote large sums of funding to HIV prevention, such as USAID and PEPFAR, who justify its application worldwide as a universalist approach that can be “tailored to meet the specific needs of the most at-risk or vulnerable individuals” (USAID, 2006). However, the utility of the approach has been called into question, as many different theories have gained currency in explaining Uganda’s success. Some researchers point to the role of governmental initiatives in lowering rates of HIV in Uganda, such as

reducing stigma, bringing discussion of sexual behaviour out into the open, involving HIV-infected people in public education, persuading individuals and couples to be tested and counselled, improving the status of women, involving religious organizations, [and] enlisting traditional healers (Green 2004 in Cohen 2002:3).

Others explain it as the result of increased death rates (combined with increased condom use) that served to drastically reduce the number of individuals living with the virus and able to spread it, as one recent study in Uganda’s Rakai district suggested (Wawer, 2005 in Harder 2005). Another prominent view instead argues that individual behaviour change towards the A’s and B’s, and away from casual sex, were most instrumental turning around the epidemic: According to a recent USAID report (2006:para. 5), the “most significant” of the factors leading to Uganda’s decrease “appear[s] to be faithfulness or partner reduction behaviours by Ugandan men and women, whose reported casual sex encounters declined by well over 50 percent.”

Another recent report has indicated that Uganda’s rate of HIV infection is rising again (Shafer, 2006), believed by some to be the result of Ugandan President Yoweri Museveni’s discouragement of condom use, as well as a condom shortage brought about by the government’s recall of several brands in 2004 due to quality

concerns. Some condoms “were found to be defective as they had a foul smell, while others had tiny holes in them” (Wakabi, 2006). The recalls resulted in a national shortage, as well as a serious loss of public confidence in the national brand, Engabu (Wakabi, 2006). According to one recent report, user mistrust in Engabu has led to a situation where 40 million condoms, nearly half of those used annually in Uganda, could go to waste due to dwindling demand (Ouma, 2007). Current president Yoweri Musaveni himself recently questioned Engabu’s safety, stating:

I am told Ngabo [Engabu] is not good, it breaks. That is another crisis. I don’t know who approved that type. It breaks and kills people. Whoever allowed the importation of that condom into Uganda is a killer. Maybe that is why the prevalence rate has stagnated because people believed in the safety of such condoms and found they break. There must be a limit to condoms, but for sure if they are well manufactured they can control AIDS (Musaveni in HRW, 2005).

In spite of these more recent controversies, the example of Uganda stood out as a beacon of hope for abstinence campaigners, seen as the only country in Africa that has been able to seemingly turn around an HIV epidemic. Matteus, the Christian sexual health campaigner, related the following statistics as evidence that abstinence, not condom promotion, had been responsible for the decline in infection rate in Uganda:

When you look at the statistics on increases in condom use, even where there is an increase of 5-17 times in condom use, there still has been no appreciable impact on the growth of HIV. In Uganda the abstinence campaign was only partially responsible – but it reduced casual sex by fifty percent – this was enough to turn around the epidemic. And this is all from a Johns Hopkins University report, it was multi-sourced. People are sceptical about Uganda, but the facts are undeniable. Science proves that the condom is ineffective in reducing the transmission of HIV/AIDS.

The view that Uganda’s approach was one that should be applied in Namibia was also put forward. As Pastor Joel, the HIV healer put it,

But they [the Namibian government] need to do more, like Uganda. Because I was told that the HIV in Uganda has been reduced drastically. So they have to ask Uganda how they did it...according to what we heard, we really don't know [how], but from what we heard at the conference, we know that HIV in Uganda has really gone down.

Related to this idea was one that in countries where Pentecostal and Christian movements in particular were growing, the rates of HIV infection were declining as well. Uganda's success was seen as being the result of behaviour change rather than condom promotion, in particular, a change to behaviours that were related to Christian lifestyles. As a pastor from Oshakati in town for a Pentecostal conference in Windhoek argued:

But you see, the Born Again faith sees things differently, it teaches you life skills, and how to respect yourself. That's why in countries where the Born Again church is growing, the HIV rate is declining, like in Uganda and Zambia. There people live their lives as Christians – it becomes something that affects your entire life, not something you just hear about on Sundays.

To the people whose views are presented above, the example of Uganda served as proof that an abstinence and faithfulness-based approach was able to facilitate behavioural change among individuals, by reducing the amount of “casual sex” taking place outside of marriage. The Ugandan government was seen as not having bowed to international pressure forcing the promotion of condoms, and further, the approach was perceived to be one that incorporated the church's position into state-level HIV prevention activities, rather than excluding religious groups from the decision making process.

The case of Uganda exemplified the vast possibilities of a Christian-led HIV prevention initiative, where condoms would lose their place of supremacy and be replaced by faith-based prescriptions leading to behavioural changes across society. As such, religious leaders felt a responsibility to promote these behaviours as viable solutions to the epidemic.

Abstinence and Faithfulness

In placing themselves in opposition to the promotion of condoms, religious leaders instead allied themselves with the Abstinence and Be faithful side of the HIV prevention continuum. Because condoms were believed to be ineffective, abstinence and faithfulness were promoted as the only truly healthy options for individuals wanting to protect themselves from HIV. As Jeanette, the director of AIDS programs at the Holy Fire church in Katutura stated, “There is only one way out away from HIV – condoms don’t work, people are still getting more sick. The only way out is abstinence.”

While it was recognized that the government was applying the ABC approach to HIV prevention, religious leaders complained that the A and B aspects of the approach had been and continued to be purposely neglected. For example, some noted the lack of advertisements on television and radio promoting abstinence as a viable prevention strategy, while others argued that there were few government-run programs or support systems available to young people who wished to remain abstinent. Thus, an emphasis was placed on addressing this lack within the churches, institutions viewed as being better qualified to support young people in such endeavours. Jeanette explains below how young congregants at the Holy Fire church were often exposed to information about sexuality and abstinence, making the choice to remain abstinent somewhat less difficult:

I think that it’s easier for people to abstain here because it’s just not told to them, but they are taught *how* to abstain. Here we speak openly about sex...at the last youth retreat the topic was ‘sex is good!’ We explained that sex is good, but it’s meant for marriage, and that’s the place where it should be enjoyed.

Abstinence and faithfulness were both seen as the only truly “safe” ways to avoid HIV infection, and in this way could be promoted as health-seeking behaviours rather than moral prescriptions. Monogamous marriage was perceived as providing the best

protection from HIV infection, and was the ideal to which most religious leaders hoped their congregants would aspire to. Religious leaders made the point that abstinence and faithfulness were necessary choices that didn't have to be difficult, often relating their own experiences with marriage and sexuality to persuade young congregants that "true love waits." Many churches had developed initiatives and formed groups specifically directed towards this purpose, although pastors reported mixed results with regard to how well young people were adhering to their abstinence vows. Dr. Ntemba, an AIDS specialist at a local FBO who was also a member of a Pentecostal church, mentioned that he knew a few choir members in his church who had become pregnant outside of wedlock, evidence to him that his fellow congregants were not really "taking the message" about abstinence. Similarly, one Catholic priest explained that although he was running a monthly abstinence support group with young people in his community, he doubted that they were actually practicing what he was preaching: "They can promise to me that they'll wait until the right time but I really don't know what they're doing behind my back when they leave, when they're in the *shebeens* with their friends, or with whoever." In these cases, marriage and faithfulness were seen as protective mechanisms against HIV, ways to keep oneself not only spiritually pure, but physically pure as well, although it is unclear whether this message has been widely adopted by congregants. Despite this, religious leaders sought to relay their messages beyond their congregations into the wider community, in an effort to reach even larger numbers of individuals.

Beyond the Pulpit

While it seems as though discourses questioning condom efficacy and promoting abstinence and faithfulness as the only truly "safe" alternatives are contained within the Pentecostal sphere, religious leaders were in fact quite active in spreading this message

beyond the pulpit. In this sense, many religious leaders saw themselves as occupying a crucial role in HIV prevention, by making it certain that young people were aware that condoms would likely infect rather than protect them from HIV. To this end, a few described to me how they had successfully tapped into the media to reach the people who weren't sitting in the pews of their churches on Sundays.

For example, Pastor Ezekiel had been successful in rallying the national television broadcaster to run an "educational" film for youth entitled *In Your Face*, produced by the religious health organization Doctors for Life (DFL) South Africa. The film portrays Dr. Albu van Eeden, CEO of DFL South Africa, giving presentations on HIV/AIDS to auditoriums filled with school-aged youth. The film relies on the presentation of a series of graphic medical images of AIDS patients with advanced stage opportunistic and sexually transmitted infections (STIs) such as Kaposi's sarcoma and syphilis, as tactics to scare young people away from sex before marriage. Stories which carry a Christian moral tone accompany the photos, disposing of patient anonymity in the doctor's quest to hold up examples of the behaviours believed to contribute to the spread of the infection. For example, while presenting a photo of a baby with facial herpes, van Eeden explains how as the child was

[...] coming through the birthing canal, his mother literally injected him in the face with the virus...it is not a joke to look at your child in the face every day and know that you gave him the virus (DFL, 2005).

Another child, whose body is covered with the open sores characteristic of congenital syphilis is described as "an innocent child...he did nothing wrong. He is suffering because of the life his mother has led" (ibid). An almost violent theatre of oppressors and victims is played out through the tales: the innocent are largely left to suffer for the

immoral actions of HIV infected people. No mention is made of the influence of social determinants which have been proven to shape one's risk of HIV infection in Southern Africa specifically, such as the widespread poverty caused by the colonial economic system, perpetuated today by structural adjustment programs that limit the reach of public health care (Schoepf, 2004). Presumably in the first world, a pregnant woman presenting with symptoms of STIs would be examined and advised to have a Caesarean section to avoid the transmission of peri-natal infections, actions that are often not undertaken in the resource-poor environments where HIV/AIDS proliferates. In van Eeden's view, it is an *individual's* responsibility if he or she has contracted HIV – and when one has done so, one is blamed for it. Young people are warned: “when you make your decisions, you alone are blamed for the choices you are going to make” (ibid).

The motif of the inefficacy of condoms is one that appears in van Eeden's film as well, again abstinence and monogamous marriage promoted as the sole actions capable of truly protecting individuals from the virus. Dr. van Eeden, maximizing the authority conferred by his professional status and invoking the power of “medical science”, exhorts young people:

Please, please don't put your trust in condoms. Medical science shows that condoms fail in 15-20% of the cases in protecting against AIDS. If you do skydiving and you hear that one in six parachutes don't work, are you still going to jump? Sex with a condom is dangerous sex, that's it (ibid).

The film was re-broadcast four times on the national television station “by request of the public”, according to a representative from the Christian organization responsible for its promotion. A few of the young people I spoke to had unpleasant recollections of having seen *In Your Face*, most recalling that they had been disturbed by its graphic and

memorable images. When I procured a copy of the film and sat down to watch it with a Namibian friend, he became uneasy, and asked if I thought that what they said about condoms was true, questioning how safe he thought he was by using them.

The organization has also been successful in rallying both the president's wife, Penchupifo Pohamba, and the wife of the prime minister, Katrina Tangeni Namalenga, both Born-Again Christians, in the push for abstinence in Namibia. Lady Pohamba was scheduled to give a talk on abstinence at the University of Namibia in October 2006, although the speech was later cancelled. In the organization's newsletter, the process by which a previous speech delivered in September 2006 was written is described:

This speech had the word abstinence in it about four times and we were worried about her keeping it like that – remembering that her husband heads the Government and that their strategy to fight HIV is condoms...Then one day I received a telephone call from the State House and a voice on the other side said, "I was baptized in your church when my pastor had the use of your baptism font and I am writing Madam Pohamba's speech. Would you like a copy?" Well this dear child of God put the word abstinence in seven times!

The speech in question was eventually delivered by Mrs. Angula, the wife of the Prime Minister, to a group of 250 Namibian school principals. *In Your Face* was also screened at the event, with the eventual result of the Khomas Region Education Board ordering almost 50 videos. The newsletter also reports that Madam Pohamba requests that the video be shown at all of her speaking engagements, despite the fact that the government officially supports the holistic ABC approach to HIV prevention.

Pentecostal Church leaders in particular seem to be highly adept at reaching large numbers of individuals (both religious and non-religious) through both media and political channels, and are making progress towards the promotion of abstinence and faithfulness as healthier choices, strengthened by discourses that raise questions about

condom efficacy in Namibia. Such practices have the potential to extend beyond simply their adherents, reaching far beyond the pulpit and into the homes and classrooms of many more Namibians. With its fear-inducing images supported by expert medical opinion, its religious associations obscured, a film such as *In Your Face* has the ability to frighten young people away from both sex and condoms – although what remains unclear is whether or not young people will misinterpret the message, choosing instead to renounce condom use instead of sex.

But are the Messages Taking Hold?

In moving from faith-based arguments that promoted abstinence and fidelity as expressions of religious morality and the use of contraceptives as an act against God, to arguments that re-cast abstinence and fidelity as “healthy” choices as compared to “unsafe” condom use, religious leaders are better able to use science to tap into the already existing doubts about condom safety circulating among young people in Namibia. The discourses are spread presumably with the intention of sowing further doubts among young people, in the hopes that they will adopt the A’s and B’s of HIV prevention, the condom eventually being pushed out of its place as the sole barrier method able to facilitate safer sex. What is worrying is that religious leaders’ depictions of condoms *are* in fact resonating among young people. I spoke to Charlotte, a young born-again Christian management student at the University of Namibia (UNAM), and Malena, an active member of UNAM’s Campus Crusade for Christ about their views about condoms. Their attitudes were worryingly pessimistic:

I don’t even trust those things [condoms]: one man was telling us that when you use condoms, there are pores in the condom. There are some tiny holes, and cells can go through the condom. The more you have sex the more of these things are deposited on you...the viruses go through the condom little by little and then you get HIV. It was one

Christian gentleman came to talk to us at UNAM, and he demonstrated as well how this was possible. People do know somehow that [condom use] is not a safe thing, but they just ignore it.

I'm part of a church that organizes youth conferences...the pastor speaks about health and wellness often. He said once, "you cannot trust a rubber – abstinence is the only way. Young people should keep themselves pure." So in that way he'll go against the fact that people say "have safe sex" – you can't trust a condom, so it's not worth it. It's sexual immorality anyway to engage in sex. There are also the dangers of HIV and falling pregnant.

Discussion

In a similar way to the approaches of global religious movements described above, Pentecostal religious leaders' discourses about condoms appropriate science to strengthen the claim that condoms are not effective in the prevention of HIV. They also articulate a lack of trust in the powers that promote the use of condoms as a safe and healthy choice in an HIV epidemic. What may motivate such an engagement with science on the part of nonscientists? Emily Martin's (1998) conceptions of the interactions between science and society are particularly useful in understanding such discourses. Martin uses the image of the *citadel* to illustrate that scientific knowledge is not confined to a fortress-like domain, but rather is often appropriated by non-scientists for strategic purposes. The scientific establishment and its knowledge are not impermeable; rather, actors interact with the world inside the citadel of science, frequently and in powerful ways. The walls of the citadel are permeable, and open to the influence of nonscientists, who are able to "alter the agendas of scientific research or the uses of scientific materials" (1998:29).

Similarly, Martin appropriates Deleuze's concept of the rhizome to capture the kind of discontinuous, fractured and nonlinear relationships that exist between science and the rest of culture. These processes are likely to involve power relations, large or small scale, and also are likely to entail a lively engagement on the part of nonscientists. Martin notes

that such engagement is especially likely when scientific developments have direct impact on the body, as do condoms and other family planning products. Further, Paula Treichler (1999) notes that the uncertainty that characterizes contemporary scientific knowledge is ironically useful in allowing a space for differing interpretations and actions on the part of numerous groups and individuals. For example, she discusses how HIV-positive activists in the U.S.A exploited ambiguities and uncertainties concerning experimental drug treatments, engaging with scientific knowledge and governmental authority to speed up the access to drugs that could potentially prolong people's lives. In a similar way, religious leaders here engage with the uncertainties of science regarding condom efficacy, revealing its inability to have found neither an effective prevention strategy nor a cure for HIV/AIDS in Namibia.

Another question raised by the above ethnographic data is whether there is any substance to the oppositional stance that pastors take with regard to condoms. Are they simply distorting established scientific evidence to lend credence to religiously grounded claims? While the promotion of condoms appears to be a relatively straightforward action, popularly accepted as a reasonable, scientifically-proven approach to preventing the spread of HIV, a wealth of conflicting scientific research currently exists concerning condom efficacy. Questions about the safety and reliability of condoms are not particular to the religious sphere, although dominant AIDS prevention discourses tend to silence these minority views. As Green (2003:95) notes,

experience shows that those who raise any sort of question about the safety and reliability of condoms become highly suspect and are often the target of accusations of having a religious or moral agenda rather than a concern for public health.

The oft-cited statistic from the US Centres for Disease Control (CDC) rates the breakage of condoms in the United States at less than 2%, and their effectiveness in preventing pregnancy (although not STIs) as up to 98% with correct, consistent use during penile-vaginal sex (CDC 1999:4). However, research concerning the efficacy of condoms in preventing the transmission of STIs, including HIV, are not as encouraging, for a number of reasons. First, researchers have noted that statistics on condom efficacy are context-specific, related not only to correct use and the quality of the product itself, but also to the material inequalities between the “West and the Rest.” In addition to problems relating to condom distribution and affordability in underdeveloped countries, Green (2003:93) notes that

condoms also have a relatively high failure rate in Africa, due to incorrect use but also due to the poor quality of condoms often found in poor, tropical countries. In fact, quality may deteriorate from incorrect or simply lengthy storage in hot warehouses or shelves of clinics or shops. Or condoms can be of good quality but the wrong size for the local population.

Second, the CDC statistic of 98% efficacy relies on ideal-use conditions, where condoms are used correctly, consistently, and only during heterosexual vaginal sex. Studies of condom efficacy in practice tend to produce much lower estimates of efficacy, due either to improper use, but also for use in practices that tend to be ignored, such as anal sex. For example, a study of condom breakage in Ethiopia among literate men measured the number of condoms broken while opening the package, putting the condom on, or during intercourse or withdrawal. Almost 27% of the 143 participants were found to have broken condoms (Mekonen and Mekonen, 1999 in Green 2003:96). Similarly, a 2003 study of condom use among American university students found that condom use errors and problems were quite common, even among well-educated individuals who had received

some form of instruction in condom use. In the sample surveyed, 11% of respondents had opened condom packages with sharp instruments, and 7% subsequently allowed condoms to contact sharp objects – both practices that may result in breakage. A further “38% reported that the condom was applied after sex had begun, and 14% reported that condoms were removed before sex was concluded” (Crosby et al. 2003:369). As these studies demonstrate, ideal-use conditions rarely exist in practice, likely reducing the “actual” efficacy of condoms considerably, both in underdeveloped and developed countries.

Third, the CDC statistic does not account for the transmission of STIs, including HIV, but only for the prevention of pregnancy. In 2000, the American National Institute of Allergy and Infectious Disease (NIAID) conducted a literature review of 138 peer reviewed studies on condom efficacy, concluding that “when male condoms are used correctly and consistently, they are *80-90% effective* in reducing the risk of HIV infection” (NIAID, 2000 in AMFAR, 2000). Interestingly, the American Foundation for AIDS Research uses this data in support of their opinion that condom use is a “highly effective” mode of preventing HIV/AIDS, in their efforts to challenge recent US government initiatives that have begun to question its efficacy. In contrast, similar statistics are used by the Namibian religious leaders above to prove the opposite. In a country where nearly one in four people are HIV positive, a 10-20% condom failure rate is likely to generate different anxieties about condom failure, and seems to result in different conceptions of the practice of “safe sex.” Perhaps reflecting these ambiguities surrounding condom efficacy, the WHO has removed statistics completely from such

- discussions, describing the consistent use of condoms as “*significantly reduc[ing]* the risk of all sexually transmitted infections, including HIV” (WHO, 2007, emphasis added).

As such, the supremacy of the knowledge disseminated by scientists, public health experts and government remains questionable in a context where HIV continues to proliferate. Religious leaders respond with scientifically-based explanations that seek to address why, despite the aggressive promotion of condoms, individuals continue to become infected with the virus. At the same time, religious leaders view the promotion of condoms as a conspiracy, accusing the power structures that have determined the shape of HIV prevention strategies in Namibia of being complicit in the spread of the disease. While these institutions claim to give structure to the “rational” and “transparent” operation of power, religious leaders instead believe that “power continues in reality to work in unpredictable ways” (Sanders and West, 2003:7). These unpredictable workings of power are believed to manifest themselves in the promotion and distribution of prophylactics that aim to kill people rather than protect them. In the context of a history of population control where the apartheid state authorized the forceful injection of Depo-Provera contraceptives and the insertion of IUDs, as well as covert sterilizations and hysterectomies, beginning in the 1970s and only ending with independence in 1990 (Lindsay, 1991), this estimation makes sense. If the apartheid government was able to control the fertility of Namibians for thirty years, it is understandable that individuals would consider that international governments and agencies who provide the free condoms available in hospitals and clinics could be acting in equally malicious ways.

Summary and Conclusion

This chapter discussed the ways in which Pentecostal religious leaders challenged the promotion of condom use as an example of “safe sex” by accessing and deploying

scientific research on condom efficacy. Such a strategy was shown to be used by religious groups outside Namibia, notably Catholics in diverse regions. While a diversity of policies and practices are apparent among religious groups addressing issues of HIV/AIDS in Namibia, Pentecostal religious leaders were shown to take a particularly oppositional stance towards the promotion of condoms. Informants described condoms as being unsafe, largely because it was believed that the HIV virus could pass through pores in latex condoms. In their efforts to discredit condoms, religious leaders also used scientific research from countries such as Uganda to prove the point that abstinence and faithfulness were the two most effective ways of preventing the transmission of HIV. The A's and B's of HIV prevention were thus more easily transformed into health-seeking behaviours rather than moral prescriptions. Such messages were also shown to be transmitted beyond the congregations of religious leaders to the general public, through the airing of religious films on the national media that called condom efficacy into question, as well as through the forging of alliances with political leaders willing to promote abstinence and faithfulness. What is apparent is that such views did resonate with some of the youth interviewed, who shared some of these same views on condom efficacy. Some of the reasons for why such discourses about condoms may be spread among religious groups, namely, that the uncertainties of science surrounding condom efficacy provide a particularly useful space on which to develop various challenges to the accepted wisdom of HIV prevention experts.

What is worrying is that events such as these are not confined to Namibia – popular doubts about condoms have also recently been observed in other sub-Saharan locales, such as Malawi, and Zimbabwe, and South Africa (Kaler, 2005; Rodlach, 2006;

Stadler, 2003), some emerging specifically from religious groups (Pfeiffer, 2004; Willms et al., 2004). Such observations point to a worrying failure in public health interventions promoting condoms in epidemic contexts, one that needs to be addressed through further research and a change in the ways in which condoms are promoted and distributed in Southern African regions highly affected by HIV/AIDS. The next and final ethnographic chapter discusses some of the failures of such health interventions in Namibia, focusing on the ways in which HIV prevention experts promote the dissemination of “correct” biomedical and scientific information as the primary way of stalling both rumours about condoms and the HIV epidemic in Namibia.

CHAPTER 5: EASY AS ABC: PUBLIC HEALTH APPROACHES TO HIV PREVENTION IN NAMIBIA

“Soldiers, sex is serious business!”

SMA informational pamphlet for the Namibian military

What remains to be explored in this analysis are the ways in which international and public health experts conceive of and promote “safe sex” as a viable and necessary option in the context of the HIV epidemic in Namibia. Despite the anxieties about condoms and safer sex outlined in the previous chapters, billboards promoting condom brands such as Cool Ryder and Maximum Gold nonetheless proliferate across urban Windhoek and beyond. Posters of the former president, local celebrities, and even “average” young Namibians adorn the walls of schools, clinics, and government offices, all of them advocating some combination of the A’s, B’s and C’s of HIV prevention. Pamphlets and brochures also abound, such as the sleek Saatchi & Saatchi-designed “How to” series that instructs young people in correct and consistent condom use, “taking control”, and fostering healthy sexual relationships. Bumper stickers inform people that “every trucker should know how to change a tyre and put on a condom!”, while television and radio advertisements promote popular condom brands. Although the internet is still a nascent and somewhat slow technology in Namibia, it too is being tapped into, to spread the stories of HIV positive youth and the issues facing them and their communities.¹² While HIV-related information seems to be everywhere, it is at the same time less accessible to some, such as those living in rural areas, or those who do not often frequent the public institutions that distribute such materials. It also seems scarce at certain times of the year,

¹² “Digital Diarist talks to other young people about AIDS”
http://www.unicef.org/infobycountry/namibia_38059.html

as information dries up while agencies develop new campaigns that are largely launched on World AIDS day each December (Schwarz, 2003a; personal communication).

In this final chapter, I present ethnographic data from interviews with HIV prevention experts, their health information campaigns, and their research materials to explore the ways in which public health experts promote the provision and adoption of information and knowledge about the ABC's of safe sex by target audiences as the principal way of halting the HIV epidemic in Namibia. In this model, the individual assumes full responsibility for internalizing the required knowledge and adopting healthy sexual behaviour. Thus, when public health experts identify "barriers" to effective HIV prevention, it is often the individual and his or her culture that are identified as the main obstacles to be overcome. By focusing on the individual's ability to internalize knowledge and by viewing individual behaviour and culture as the primary barriers to effective health promotion, the importance of the social determinants of health are minimized. Such determinants include factors such as income inequality, employment, housing, and social support networks (Health Canada, 2003), and their influence upon healthy behaviour and disease avoidance has been elaborated upon by a number of researchers (Bezruchka, 2001, Campbell, 2003; Farmer, 2005, Hertzman, 2001). Despite this, information campaigns tend to view target audiences as individuals liberated from their social contexts who are capable of unproblematically choosing safe sex, despite the limitations and constraints social determinants tend to place upon the maintenance of good health.

The materials presented below tend not to address the concerns about "safe sex" expressed by the young people and religious leaders related in the previous chapters, such

- as condom breakage, perceived low condom efficacy, and mistrust in health interventions. When such concerns are acknowledged in the literature, they tend to be
- discounted as “myths” or “rumours” and are usually countered with biomedical and scientific evidence. Further, issues of trust, intimacy, financial constraints, and many
 - other social determinants of condom use that the people that I spoke to revealed to me remained obscured and unexamined within public health discourses about safe sex.

Is Knowledge Power?

Within the materials I examined, gathered both in 2004 and 2006, the ways in which condom use is promoted as a healthy behaviour is generally consistent among materials – as a rational, reasonable, and individually-controlled response to widespread HIV infection in Namibia. A central goal of these materials is the provision of factual information, presented in unequivocal terms, that presumably serves to both educate and reassure individuals about their ability to protect themselves from HIV infection. A recent UNICEF Namibia report summed up this position thusly: “In the fight against HIV & AIDS, the provision of correct information remains the most effective weapon” (Schwarz 2003a:7). However, as this section demonstrates, the ability of many young Namibians to apply this information and “reasonably” follow its directives is questionable within the social context in which many of them live.

A common assertion seen in the variety of materials developed for the many target audiences towards whom HIV prevention information is directed is that informed individuals are empowered to protect themselves from HIV (See Figure 9). For example, one recent initiative by a condom social marketing (CSM) organization was the distribution of a deck of “Learn about HIV/AIDS” playing cards marketed towards the general population, as well as police officers and soldiers. The cards are imprinted with a

variety of healthy messages portraying knowledge about HIV and the decision to use condoms as the essential variables that will allow individuals protect themselves from the virus. Card players are instructed, “Everyone has the right to say no to unsafe sex”; “Fact: Sex with no condom is risky”; and “Stop the spread of AIDS: Use a condom for each round.” A NaSoMa pamphlet entitled “protect your dreams” instructs sex workers to “respect yourself enough to insist on using condoms with all your partners, including the ones you trust” and to “make sure you persuade your customer to always use a condom. You have the right to protect yourself.” These catchy slogans give the impression that preventing HIV is an uncomplicated action that can be undertaken by each individual, if only they adopt the necessary information and make the decision to safeguard their health.

Figure 9: SMA Condom Ad



Not surprisingly, public health experts largely echoed the sentiments found in these informational materials. In a recent media interview, Otilie Lambert, manager of Behavior Change Communications (BCC) at Nasoma, explained why she believes that certain women have difficulties getting their partners to use condoms, asserting that

individuals can be trained in effective HIV prevention behaviours: “some women are just shy and others don’t know how to go about negotiating for a man to wear a condom and these are some of the things we are emphasizing during our workshops and training to encourage women to do every time before having sex with their partners” (Lambert, in The Namibian, 2006).

Also apparent in these materials is the belief that more information can alleviate the fears associated with HIV, by allowing individuals to respond reasonably in the face of the epidemic. As another card in the CSM deck instructs players, “Don’t be afraid, find out about AIDS!” However, for the young people I spoke to, who were for the most part relatively well-informed about HIV/AIDS, information was not necessarily enough to quell their anxieties. For example, Joseph, a young high school teacher who I met at a Pentecostal church service, told me about the time that he had to take care of a cousin who had recently revealed his HIV positive status to him. Joseph told me that although he knew the routes of HIV transmission well, he couldn’t help but to become nervous when he heard the mosquitoes buzzing around the bed that night.

I knew that HIV couldn’t be spread by mosquitoes, I knew that. But I also knew that he was in the next room, and I couldn’t sleep at all – I was just thinking that maybe it was possible, that maybe we don’t know enough about how the disease is spread yet.

Nadira, a young woman who I met in a shebeen in Katutura, echoed Joseph’s concerns in explaining that despite all the information in her possession, as well as personal experience with HIV, she was still very afraid of the virus:

You see, people here are very afraid. Me for example, I have three people who are close to me who have died of HIV, my father, my younger sister and my cousin. And still, when they got sick, I did not want to stay close to them or care for them – I was afraid. I don’t know why. I had to bathe my sister one time when she was in the hospital,

because the nurses don't do it, they don't do anything. And I just didn't want to. I was afraid of catching the disease...she had all of these wounds over her genitals and I didn't want to touch her, even though I had gloves. And this was a person who I have grown up with, who I spent my entire life with. And still I was so afraid of catching something from her. It's not like this with other diseases, like if someone has cancer or something. It's only with HIV that people are afraid of their loved ones like this. And it's not just me who feels this way, it's everyone.

The notion that there is a linear relationship between the possession of biomedical knowledge and engaging in behaviours that promote good health is one that has been heavily criticized (Bloom and Novelli, 1981; Farmer, 2001; McKenzie-Mohr, 2000; Yoder, 1997). Catherine Campbell's (2003) analysis of a failed HIV intervention in Summertown, a South African mining town highly affected by HIV, offers a powerful critique against the provision of information as a viable solution to the epidemic. As Campbell (2003:10) asserts,

Giving people information about health risks is unlikely to change the behaviour of more than one in four people, and these are generally the more affluent and better educated members of a social group. This is because health-related behaviours (such as condom use) are determined not only by conscious rational choice by individuals, on the basis of good information, but also by the extent to which broader contextual factors support the performance of such behaviours.

According to Campbell, young people in Summertown faced a variety of constraints that mitigated against the safe sex and condom use being promoted by HIV prevention experts there, including

low levels of perceived vulnerability to HIV despite high levels among their peers; peer norms around sexuality and condom use; limited access to condoms; adult disapproval of youth sexuality and condom use; gender inequalities; and economic constraints that impacted on young people's sexuality in a range of complex ways (2003:123).

Paul Farmer (2001) illuminates some of the ways in which such constraints can impact one's ability to avoid disease through an exploration of how racism and poverty may increase an individual's likelihood of becoming infected with tuberculosis (TB). Farmer explains that the poor are often more likely to live together, often in the cramped, airless quarters found in urban ghettos and homeless shelters, thus increasing the possibility of disease transmission and infection. Once infected, poorer individuals are also more likely to have TB progress to active disease, for a number of reasons. "Cell mediated immunity, which keeps tuberculosis quiescent in most persons, may be compromised by malnutrition, HIV infection (or other concurrent disease), or addiction to drugs or alcohol" (2001:13). Poverty and racism also influence outcomes of those with active TB disease, by "restricting access to effective therapy or rendering it less effective if patients are malnourished or addicted" (2001:14). In this way, poor and marginalized communities often bear a disproportionate burden of disease as compared to their wealthier counterparts, a pattern that is repeated for a multitude of diseases. As Farmer concludes, "thus do fundamentally social forces and processes come to be embodied as biological events" (ibid).

Similar issues seem to be shaping young people's risk of HIV infection in Namibia. While individuals should ideally have the right to say no to unsafe sex, the range of action available is somewhat more limited than the simplicity of using condoms or "just saying no" implies. Rape is one of the most often reported crimes, with Namibia ranking third place out of 53 countries surveyed by the UN for reported rapes (Namibian Economist, 2006). Presumably these statistics do not accurately depict the reality of rape in Namibia, due to underreporting. In addition, "survival sex" relationships appear to be

relatively common in Namibia, making the public health insistence on safe sex problematic. Women's financial reliance upon men seems to be prevalent in Namibia. One recent study among poor Namibian women noted that female dependency on male patronage was "often the primary reason cited for the lack of women's sexual autonomy", and impacted their ability to practice abstinence, ensure that their partner was being faithful, and to use condoms (Edwards 2007:240). Ipinge (2004:34) acknowledges that it is "the practice of younger women providing sex for financial support", as well as the "desire for the three c's – cash, cars and cell phones" that often motivates unsafe sexual practices. The lesbian, gay, bisexual and transgender (LGBT) community in Namibia seems to be facing similar challenges to practicing safe sex. Lorway (2006:448) notes that young gay Namibians in Windhoek often found themselves in unequal relationships with both foreigners and men who occasionally have sex with men. Condom use is a choice that often remains outside the grasp of young homosexuals, as safer sex negotiations would "often 'break-down' unevenly for persons in same-sex sexual relationships around notions of gender, class, race and ethnicity" (ibid). Many young women also brought up infidelity as an issue that affected their relationships, and by extension their health. While having lunch with some students one Sunday afternoon at my home in Windhoek, the conversation turned to relationships, as it often did. Jackie, a nineteen year-old student, related to us the story of her cousin as evidence that women often found themselves remaining in relationships with men who were unfaithful, for a number of different reasons:

My cousin is thirty, he just got married a year ago to his wife. Already three months after they married he cheated on her with her own cousin, and got the girl pregnant. She decided to have the baby, and his wife took him back; she didn't say a thing, she just forgave him. He

promised it wouldn't happen again, and what do you know, a few months later he got his *own* cousin pregnant too! She also wants to keep the baby. And again, his wife took him back. I think maybe she can't have children or something, and maybe she stays with him because of that, because she knows she won't be able to find somebody else. But you see, that's how it is in Namibia. My own father has many other children by many different women, I don't even know them all. Ask any one of us around this table, which one of us can say that our boyfriends are not cheating on us? None of us can. All men are doing these things.

In remaining in relationships with cheating partners, young women may believe they are engaging in safe sex by following the public health directive to "be faithful", although this may not be the case for their partner. As other studies have indicated, condom use in Namibia may not be pursued in committed sexual relationships because the partner who proposes condom use may be accused of infidelity (Schwarz 2003b:66).

The types of contraception that young people are encouraged to use, as well as the reasons for why they use them also provides some insight into why and how unprotected sex comes to occur. One conversation that I found particularly insightful was one that I had with Keisha, an eighteen year-old mother and high school student, and Oswaldo, a young Christian classmate of hers. The two held largely contrary opinions on safe sex and HIV/AIDS, and I was worried that the discussion would turn into an argument, although it never did. Keisha was explaining the reasons why she felt many women, including herself, were compelled to use injection birth control instead of condoms, and how it wasn't often a personal choice:

Nicole: Is it true that they force young girls to get the injection after giving birth?

Keisha: It's true! Like me! But you have a choice, yeah, you are going your own way. But they are not asking you! Maybe your parents will tell you that you have made a mistake, and you might make the same mistake again. You have a choice, but in life basically you don't have a

choice. You have to use the injection to protect yourself from having another baby.

Oswaldo: No, but I disagree with exactly what you are saying. Keisha, the use of these injections, for your health...how are you going to know you are not getting any other disease? Not particularly HIV, but any other disease?

K: ok...that's why I am saying, when you use the injection, that is only preventing you from getting pregnant. It's not protecting you from HIV, STDs, and stuff. Because you're using the injection, you also have to use the condom.

N: I know some people who just use condoms, and don't get the injection...so do you need to have both?

K: If you're on family planning, it might happen that you are out at a club, and you are raped! And then you're not using a condom. Most rapists do not use a condom. In Namibia they are raping girls like nothing.

O: Are you saying that you are using the injection because you need to protect yourself from a rapist?

K: Both. Sometimes the girl is shy to talk to someone...then maybe a month after it is haunting her she will come to her mom and say, 'mom, this happened to me 2 months ago.' Now she's pregnant. That's what I'm talking about. You have to be sure!

O: But if you don't want to get pregnant, you take the injection. You only get pregnant when there is physical contact.

K: What I'm saying, is that you have to use the injection. Maybe you're not sure, someone is raping you, and then...

O: you cannot really...

K: There are also uncles who are abusing their children, in their homes, maybe, and that can also happen without a condom. And now you know I am using the injection maybe it will prevent me from getting pregnant. In Namibia you can't trust anyone. But if you are using a condom consistently, there is no need to use the injection. But there are many side effects to the injection. It lasts for six months. For example, the Depo lasts six months. That one is very dangerous for you. After five years you won't be able to have babies. You get counseling

before....there are different kinds of family planning methods – they are telling you that you have to choose what you want.

While in some ways, Keisha may have been seeking ways to justify her decision to take contraceptive injections to Oswald, who did not agree with the practice of premarital sex, a number of the themes she brought up were ones that I heard from others as well. The many barriers to practicing safe sex brought up in this one conversation – early pregnancies, family pressure to take injection contraceptives, rape, and abuse illustrate that the simplicity of choosing to use a condom is not a reality for all, despite the assertions of the public health materials that imply otherwise.

Access to adequate health care is also an issue that impacts upon one's ability to treat STDs, and hence protect oneself from further vulnerability to HIV infection. While the directives in the STD brochure above imply that treatment is a reasonable option available to all, the realities of poverty, as well as inequalities within the two tiered private/public health care system in Namibia tend to complicate matters for those seeking treatment. Tooley and Ashipala's (2004) research on the introduction of anonymous Voluntary Counselling and Testing (VCT) clinics in Namibia reported that the ability to pay for transportation to clinics, health services, and medications made testing and treatment a near impossibility for many urban Windhoekers. A perceived lack of confidentiality within the healthcare system was also identified as a problem, as informants reported that health care professionals would often loudly reveal patients' illnesses publicly in the clinical context and in their communities.

HIV prevention experts' emphasis on knowledgeable decision-making by individuals as the key to disease avoidance also makes it simple to "blame the victim" when a health intervention does not function effectively. This can be seen in materials

that discuss condom use, which is seen as a simple adoption of a technology by individuals. Condom use is supported with the use of scientific research that endorses its efficacy and safety; when condoms fail, it is condom *misuse* by individuals lacking the correct information on how to use them. Likely in response to popular doubts about condom efficacy in Namibia, the “How to use a condom” pamphlet produced by Take Control uses scientific data to explain that condoms confer a high degree of safety, as long as the *individual* uses them correctly:

Condoms cannot offer 100% protection against HIV-infection. Still, when you use condoms correctly and consistently, the chance of contracting HIV is very low. For instance, among HIV-negative persons that were having a steady HIV-positive sexual partner, less than 1 out of every 100 became infected over a whole year when always using a condom. *When a condom fails, it is almost always because it was not used correctly. So, make sure you use your condom right and every time you have sex* (emphasis added)

Similarly, a government official directing the distribution of condoms in Namibia also explained the high number of reports of condom failure to her office as being primarily the result of individual misuse:

There's a process in place right now to send [condoms] for quality testing...there's a condom factory and there's a lab in Zimbabwe where they're ISO tested. The test used here is a factory one. As for condoms bursting, I think it depends on how people use them. They can easily burst if they are not used properly.

Perfect use, that is, in cases where correct and consistent use is practiced, is depicted as a generally “safe” action. It is only with the interference of the ignorant individual that efficacy plummets. In this sense, condom failure is blamed on individual error, and again, social contextual factors, such as lack of condom availability, the absence of the social empowerment to use condoms, lowered condom quality or lack of appropriate sizes that may increase condom breakage, and so on are discounted.

In this sense, safe sex, condom use and STD treatment cannot be seen as neutral and reasonable actions, but are entangled with issues of poverty, intimacy, obligation, and trust. Possessing information about how to practice safe sex does not necessarily allow an individual to transcend his or her social context, which tends to limit the ways in which such information can be applied.

While HIV prevention experts tend to focus on knowledge and the dissemination of more information over social context as primary determinants affecting one's chances of becoming infected with HIV, they seem to paradoxically recognize that this focus is not having the intended effect. A recent Johns Hopkins report found 60% of young Namibians surveyed thought it was possible that they would become infected with HIV in the next 12 months, even though they possessed a knowledge level of "94% or higher" about HIV and prevention methods (Witte et al. 2003:24). The authors concede in their conclusion that "this fatalism toward HIV infection is an alarming contradiction to the high levels of knowledge and awareness about HIV/AIDS and protection methods. Further research is needed to assess reasons for these fatalistic attitudes in the face of so much knowledge" (Witte et al. 2003:24). What is also relevant in the above report are the ways in which public health experts can on the one hand identify the social determinants that negatively impact health, yet are unable to link these determinants to the very behaviours they are attempting to modify, as the following passage illustrates:

It is not surprising that with unemployment so high among the respondents, their leisure time is spent on TV and Radio. The average number of hours spent watching TV and listening to Radio offers opportunities for reaching young people through the media. In fact, the high recall of media messages coupled with changes in behavior demonstrates that media campaigns have been effective (Witte et al. 2003:25).

Public health experts thus seem capable of recognizing unemployment as a central issue, and yet understand it only in terms of its utility in allowing their target audiences the free time to absorb more health information. No mention is made of the influence that unemployment itself may have on health-seeking behaviour, such as poverty, lowered self-esteem, or a reliance on survival sex for income. Despite the previous admission that youth exhibit high levels of fatalism concerning their HIV status, the report nonetheless vaunts the success of the media campaigns in changing behaviour, despite the fact that Namibia's HIV seroprevalence has not decreased markedly in recent years.

What is apparent in the public health approach that takes a lack of information rather than social context as a starting point is that it does not account for the myriad ways in which individuals conceive of the presence of the disease in their lives, or are constrained by material realities. For these reasons, the public health messages promoting condom use as a choice made by rational individuals seeking to protect their health does not necessarily reflect the reality of choices available to and constraints upon young urban Namibians.

Cultural Barriers, Rumours and Myths

When public health experts contend that more information is the solution to the HIV epidemic, a principal barrier in the way of ending of the HIV epidemic thus become the "cultural barriers" that are in opposition to good health. As Airhihenbuwa and Obregon (2000:11) note, this dualism is common among public health experts engaging in cross-cultural interventions, where the term "*barrier*" often becomes a coupling metaphor with culture", with Western culture serving as the ideal that promotes good health. "Knowledge" thus becomes the repository of biomedicine, while culture becomes the repository of "beliefs" (2000:11). I would further argue that the materials I introduce

below present “myths” and “rumours” as types of “cultural barriers” to be overcome with the adoption of biomedical knowledge.

The discourse of cultural barriers appears to be common in the public health literature on HIV prevention in Namibia. A 1998 WHO document on family planning uses this discourse to explain barriers to condom use: “In Namibia, condoms have been difficult to introduce in some areas due to *cultural beliefs*. Many people still believe that the spermicides used in lubricating some condoms can cause sterility” (WHO 1999:6, emphasis added). No background information is provided on the historical reasons why such beliefs may exist, such as the rather grim colonial history of South African population control discussed in chapter one. Similarly, a UNAIDS document prepared by Population Services International (PSI) explains how condom social marketing (CSM) is a necessary service in developing countries argued to be able to

...help populations to overcome *social and cultural resistance* to practicing effective HIV/AIDS prevention by making condoms widely available and visible in society, thus “normalizing” them and removing some of the associations that they may carry with the commercial sex trade (UNAIDS, 1998:5, emphasis added).

Another Johns Hopkins report discusses some of the barriers to HIV counselling in Namibia, appropriating the words of focus group participants to provide a “straight from the horse’s mouth” account supporting the claim that culture is a significant barrier to HIV/AIDS interventions:

One adult male in Keetmanshoop felt that culture could be a barrier to counseling: “Our parents told us not to ask questions, but to do as we were told.” He also mentioned that children at school are not encouraged to ask questions. Many respondents agreed with this [...] An adult male respondents in Oshakati attributed people’s reluctance to ask questions to Black culture: “Black people will not say that they do not understand” (RFS 2005:25).

The influence of colonialism in developing a culture of obedience in Namibia is not explored in these passages, nor is the role of the apartheid government in creating the Bantu education system in 1962, which, through a purposely limited curriculum for non-white students, “ensured that the colonial power would be provided with a steady supply of semi-literate, subservient farm and house labourers” (Dunn, 2003). Instead, the above passage implies that a homogenous “Black culture” (even though Namibia is home to a variety of distinct linguistic and cultural groups) is essentially to blame for the failure of the intervention in question. The possibility of a culture of the oppressed, brought about by a history that remains unreferenced, is ignored. In this way, cultural resistance can only be perceived as an issue that will be resolved simply with the provision of Western knowledge and technologies imported by Western experts, while the social context in which such “resistance” emerges is ignored.

“Myths” and “rumours” surrounding safe sex and condom use are also placed under the umbrella of African cultural barriers to be replaced with biomedical knowledge if the epidemic is to reach its conclusion. A 2003 BBC report entitled “Myths blunt Africa’s fight against AIDS” reports on the existence of HIV myths, among them reports of school-aged youth in Mozambique, who similarly to the individuals I spoke to in Namibia, believe that free condoms are “infected by foreign countries wanting to kill Africans.” In response, Richard Delate, a former UNAIDS worker and now private consultant, comments on the low levels of knowledge about HIV/AIDS in “Africa” in general, arguing that

When people have more knowledge and information about HIV/AIDS the beliefs in myths are diminished. Therefore, efforts need to be maintained to provide people with accurate information regarding HIV/AIDS and to dispel the myths as they arise (Swindells, 2003).

Such a discourse is echoed in public health materials in Namibia, which often categorize myths as “beliefs” which must be replaced with biomedical knowledge. Many public health experts derided the rumours about condoms and safe sex that circulated in Namibia, explaining that many efforts were being made through their media campaigns to re-educate the masses about condom efficacy. For example, one Take Control brochure on condom use addresses the anxieties about faulty condoms that were explored in Chapters 4 and 5. The expert opinion presented attempts to counter these “myths” with expert assurances that the devices are in fact scientifically tested and are all locally produced, arguing that “Free condoms are now all produced and controlled in Namibia and have to pass rigid quality tests” (How to use a condom, 2004).

A UNICEF report more directly refers to myths about condoms, describing how some parents discouraged the use of condoms “because they believed in the myth that they carry the HI virus” (Schwarz 2003a:96). Again, this report concludes that knowledge is the best way to counteract myths. Despite the already high levels of knowledge about HIV in Namibia, there seems to have been little impact upon the spread of counter-discourses about condom safety as related in chapters 3 and 4.

Myths are related not only to condoms, but also to non-biomedical ways of relating to illness. In an interview conducted by UNICEF with Rick Olsen, project officer for UNICEF Namibia, he relates some of the myths relating to traditional healing and HIV:

Some people still believe Traditional Healers can cure AIDS. Our pre- and post- tests ask about traditional healers being able to heal HIV. MFMC [My Future is My Choice – Namibian HIV education program] participants still score poorly on that question in both pre- and post-tests. We looked into it and realized it must be because we only have

one line about traditional healers in the teaching materials (Olsen, 2001: para. 4).

The presence of myths here is again related to a lack of biomedical knowledge: individuals are perceived to believe in the strength of traditional healers not because they willingly conceive of health and disease in distinctively non-Western terms, but rather because they simply lack the Western-developed knowledge required to choose the correct answer on a survey and hence to indicate their ability to make rational health choices.

Religion, along with myth, is also constructed as a sort of cultural barrier, one that can presumably be worked at and overcome. In a recent insert about condom use in the *Namibian*, the national daily newspaper, a representative from NaSoMa describes the presence of these obstacles:

When we first started in 2000, the biggest obstacle in our way was people's religions. Some people said they won't use condoms because their religions are against it. Later we discovered that people were simply not used to condoms...there were also many myths around condoms which caused distrust from society (Namibian, 2006).

In contrast, local ASO workers tended to see the distrust towards condoms in different terms, and didn't easily adopt the "culture as barrier" model in explaining difficulties related to condom use. Many identified poverty, unemployment, gender inequality, alcohol use, and the inequalities that persist in post-colonial Namibia as social factors that made safe sex a difficult choice for many Namibians. Yvonne, a coordinator for a local ASO for youth, plainly explained individuals' mistrust of condoms in this way: "People were poisoned during the colonial struggle...it's a matter of trust. That trust has not yet been recovered."

As Airhihenbuwa and Obregon (2000:12) note, in the health promotion literature dealing with culture, it is rare to see 'strength' coupled with the concept of culture, although 'cultural barrier' is commonly cited as a reason for failure in public health and health promotion and communications programs. Yoder (1997:138) elaborates upon some of the reasons why such a dualism may continue to persist:

Setting up belief and knowledge as clearly contrastive has certain advantages for health educators, since the task of health education then becomes teaching biomedical knowledge to a population unaware of its implications. This approach fits well with our own commonsense tradition, which conceives of lay knowledge of medicine as a faulty derivative of biomedical knowledge. It assumes that as knowledge improves in accuracy, healthier practices will follow. When they do not, this may be explained by citing local cultural beliefs, as the "culture as difference" assumption suggests.

In this sense, the failures of HIV interventions in Namibia are not likely to bring attention to the inability of public health experts to address the social contexts that make the adoption of healthy behaviours challenging for individuals. Rather, the individual and his or her "pathological" culture remain the barriers to health to be addressed through the provision of knowledge and technology by largely Western experts in their attempts to manage the epidemic.

Summary and Conclusion

This chapter sought to demonstrate the ways in which public health experts often construct individual and societal adoption of biomedical knowledge and information about safe sex as the *primary* ways of ending the HIV epidemic in Namibia. The informational materials about HIV/AIDS in circulation in Namibia attest to this claim, by both identifying and attempting to create the knowledgeable, individual agent as one of the foundations of successful HIV/AIDS interventions. As a result, the centrality of the social determinants of health proven to influence healthy behaviours, such as poverty,

unemployment, and gender inequality are effaced, and the individual comes to bear the burden of successfully undertaking healthy behaviours. “Cultural barriers” to safe sex thus become another strong focal point of HIV interventions, and are associated with ignorance and beliefs in myths and rumours that must be quashed with the imposition of Western biomedical knowledge. While it is consistently argued that knowledge and more information are the keys to ending the HIV epidemic in Namibia and Africa more generally, little evidence exists that individuals in possession of biomedical information are better able to engage in health-seeking behaviours (Campbell, 2003; Farmer, 2001). The research of HIV prevention experts attests to this in conceding that despite the fact that knowledge about HIV prevention methods among young Namibians is high, at 94% or higher, fatalism about becoming infected, as well as a continuing tide of new infections, continues to be a fact of life in Namibia (Witte et al. 2003:26). Despite this, individuals and their cultures continue to be seen as the primary obstacles to effective health interventions, thus leading to calls for more funding and research to be directed towards increasing the depth and breadth of knowledge of target audiences, largely orchestrated by teams of international experts.

Such a perspective discounts the myriad ways in which individuals conceive of health and disease, as well as the reasons why they are either incapable or unwilling to endorse or engage in the behaviours that HIV prevention experts promote. As was seen in chapter 3, “rumours” or counter-discourses tended to be spread under specific circumstances, such as situations that were ambiguous, important, or anxiety-filled (Rosnow and Fine, 1976; Shibutani, 1966). They also tend to occur in locales where histories of abuse have taken place, such as the case of pre-independence public health

and family planning in Namibia. Young people's mistrust in efficacy of free condoms appeared to be a health-seeking strategy, as the good intentions and reputations of their suppliers could not be assured, whereas suppliers of branded condoms could be trusted. Similarly, Pentecostal religious leaders challenged condom efficacy as it was promoted by experts, seeking out scientific evidence that would prove that condoms were not as effective as their promoters claimed. In so doing, they were better able to promote abstinence and faithfulness as morally acceptable and "safe" options for their congregants. Such actions do not imply ignorance or a lack of knowledge, but rather reasonable and strategic responses to the threat of HIV/AIDS. While HIV prevention materials attempt to further convince Namibians that condoms and safe sex are effective ways of combating HIV, they tend to do so in a social vacuum; while they vaguely make reference to the lack of trust in HIV interventions, they seem to avoid validating the concerns and recognizing the motivations of the above groups, instead choosing to discount them outright in favour of the dissemination of "correct" biomedical information. It seems unlikely that such strategies will reconcile the myriad perceptions about condoms and safe sex currently in circulation in Namibia, which do not show any sign of receding.

CONCLUSION

The promotion and distribution of condoms is currently taken for granted as one of the pillars upon which effective HIV prevention for developing countries stands. This thesis attempted to reveal some of the unexpected difficulties which may be encountered in promoting safe sex and condom use in locations where HIV is endemic. It attempted to answer the question of how conceptions of “safe sex” differ among three groups whose participation hinges upon the success of HIV prevention strategies in Namibia: young people, religious leaders, and HIV prevention experts. Central to these differing conceptions was an analysis of rumour, and how the deployment of such a term by health experts tends to obscure the myriad reasons for the proliferation of discourses questioning established HIV prevention wisdom. In this sense, it explored the ways in which HIV/AIDS is not simply a biological or biomedical epidemic, but is also, as Paula Treichler (1999) has noted, an *epidemic of signification*. In this parallel epidemic, meanings multiply wildly and at an extraordinary rate, resulting in the “chaotic assemblage of understandings of AIDS that now exists” (1999:11). Throughout this thesis, I have attempted to delve into the assemblage of understandings about condoms expressed by young people, religious leaders, and HIV prevention experts. Each group understood the practice of “safe sex” and condom use in different and sometimes contradictory ways: Youth thought safe sex to be safest with the use of branded and reliable condoms, whereas the use of free, government-distributed condoms were thought to be capable of infecting users with HIV. Pentecostal religious leaders questioned the safety of condoms in general, accessing scientific research to question their efficacy in the prevention of HIV, and to better promote abstinence and faithfulness as the “safest”

options. In contrast, HIV prevention experts largely conceived of safe sex as a rational choice made by individuals to either abstain, be faithful or use condoms, conceiving of anti-condom discourses as “rumours” or “myths” best combated with the dissemination of biomedical information.

Given these occurrences, it seems as though certain difficulties may exist in effectively promoting condoms for the purposes of HIV prevention in Namibia. By revisiting the main points of each chapter, I would like to reiterate the argument that in developing countries highly affected by HIV, the condom is likely to generate unexpected anxieties, leading to difficulties in effectively promoting its adoption. Before proceeding, I would like to acknowledge some of the limitations of this research.

Limitations of Research

First, it was beyond the scope of this project to determine if the discourses about condoms described in previous chapters actually influence individual sexual behaviour. As Yoder (1997) has noted in his criticism of individualistic public health models, a straightforward connection has not yet been established between knowledge and behaviour. If this is true for biomedical knowledge, one can assume that it would be true for other types of knowledge, such as doubts about condom efficacy.

Since the research took place only over a few months, and involved diverse groups, it was difficult to conduct a large number of in-depth interviews. However, other researchers have noted similar anxieties about condoms in other countries affected by HIV/AIDS (Kaler, 2004; Pfeiffer, 2004; Rodlach, 2006; Stadler, 2003), as well as within Namibia (Ipinge, 2004; LeBeau, 1999; Mufune, 2005; Yamakawa, 2001). I also only had access to the of informational materials on HIV/AIDS in circulation that I came across

during my stay, although these materials were quite numerous and were collected over 5 months in both 2004 and 2006.

The multiple meanings of “safe sex”

I have attempted to demonstrate the ways in which conceptions of “safe sex” differ fundamentally between religious leaders, young people, and HIV prevention experts in Windhoek. My research indicates that neither young people nor religious leaders have successfully internalized HIV prevention messages promoting condom use as an example of “safe sex” in the ways in which their proponents may have desired.

Young people challenged established public health wisdom largely by applying free-market principles to identify the most worthy condoms in their efforts to redefine “safe sex.” The government, cognizant of this occurrence, released the Smile condom in 2006, emphasizing aspects such as perceived value and place of origin, by adding colourful packaging and a mock price, and by emphasizing the product’s “Namibian” roots in the development of the condom. These actions were presumably taken in order to generate a renewed trust in government-supplied condoms for HIV prevention, where trust had been reportedly lacking in individuals’ perceptions towards free condoms. For many of the young people I spoke to, “safe sex” could be made safest by purchasing and using higher-priced condoms, and by avoiding condoms associated with the Ministry of Health and Social Services.

In contrast, for religious leaders, abstinence and faithfulness constituted the only examples of “safe sex” open to Namibians, while condom use was instead constructed as an “unsafe” activity. In a similar way to various international Catholic dioceses that have begun to question condom efficacy, Pentecostal religious leaders actively disseminated counter-information about the safety of condoms, resisting dominant HIV prevention

strategies in the process. Instead, religious leaders aimed at developing a parallel epistemology of HIV/AIDS that engaged with the uncertainties of science in order to give weight to religico-moral prescriptions. In taking such a stance towards condom promotion, religious leaders seemed better able to promote the A's and B's of HIV prevention as "healthy" choices relying on individual moral and behavioural change rather than upon a dependency on medical devices that may or may not function as advertised. By engaging with science and contesting its claims, this oppositional and sometimes conspiratorial approach seemed to do much more than the faith-based arguments that preceded it: the argument that condoms should not be used because they interfere with contraception was one that was rarely heard. In this sense, religious leaders were able to justify religious beliefs within secular and scientific knowledge, lending greater legitimacy to their claims.

What is clear from these occurrences is that the public health position of defining alternative discourses about condoms and safe sex as "rumours" or "myths" that can best be counteracted with the dissemination information both obscures the deeper reasons for their spread and does not adequately address the problems that may arise from such discourses. Sociologists have noted that rumours are far from being simply a form of misinformation that can easily be counteracted with official knowledge, but instead highlight that they occur under specific conditions and circumstances. Personal and situational anxiety, ambiguity and importance are some of the environmental factors that have been theorized as being particularly amenable to the spread of rumour (Rosnow and Fine, 1976; Shibutani, 1966). These four features are also an unfortunate accompaniment in places where HIV/AIDS has become endemic, as death, illness, poverty and family

breakdown continue to occur daily and on a massive scale. As anthropologists have noted, histories of abusive measures employed by the state also seem capable of precipitating the spread of health-related rumours among citizens, leading to citizen rejection of health services and interventions, often based on mistrust in the intentions of their developers (Briggs, 2004; Feldman-Savelsberg, 2000; Nichter and Nichter, 1989; Scheper-Hughes, 1996). In Namibia, a history of population control by the South African government, where active efforts were made to reduce the size of the black population through family planning policy (Lindsay, 1996), as well as subjecting blacks to humiliating STD tests (Wallace, 2002) may have in part contributed to mistrust in condom distributors and contemporary anxieties about the safety of using condoms. Further, the lack of knowledge concerning the *expert systems* (Giddens, 1990) that orchestrate the manufacture and distribution of condoms may exacerbate the mistrust motivating condom counter-discourses, as individuals remain disconnected from the knowledge about the thin piece of latex that ultimately stands between them and a fatal disease. Finally, counter-discourses about condoms are not simply steeped in ignorance, but are also a strategic action, as in situations where they have been employed by religious groups as a form of resistance against dominant, secular HIV prevention strategies (Pfeiffer, 2004; Willms et al., 2004).

Despite these events, HIV prevention experts constructed mistrust in and counter-discourses about condoms as irrational, and constructed condom use as a simple behavioural change based on the possession of information and rational health-seeking principles. Despite the demonstrated impact that structural determinants play in shaping health-seeking behaviour, HIV prevention experts continue to locate the source of the

problem of safe sex within the individual and his or her culture, addressing rumour as a type of discourse to be extinguished with the provision of more information. Public

- health experts seem to assume that condoms are able to act as a quick technological fix, essentially promoted in the same ways as they would be in a Western context.

Unfortunately, the responses to condom promotion in Namibia have not mirrored those seen in Western nations.

Recommendations

What may some of the ways out of the impasse between biomedical knowledge and counter-discourse be? Communication between HIV prevention experts, young people and religious leaders seems to be necessary to avoid confusion and anxiety about the efficacy of condoms among the general population. This may be easier said than done, however: when discussing the possibilities of communication or collaboration between largely secular HIV prevention experts and religious leaders, informants seemed to believe that the differences between these groups were too vast for any common understanding to take place. One social marketer took an antagonistic position towards any possible collaboration between his organization, concerned mainly with the social marketing of condoms, and churches:

On the role of the churches in HIV prevention: what can their role in condom promotion be really? Most of the time they are fundamentally opposed to what we are doing, so inviting them to the table doesn't really help. They just won't show up.

Some health experts discounted the potency of religious leaders' messages about condoms, believing that they would appeal only to those already convinced of the truth of Christianity and its teachings. Others saw the targeted recipients of such messages as rational enough to be able to filter out the "noise" of competing discourses in order to

make the “right” choice relating to their health, as one government condom promoter stated:

If you have conflicting messages, we say this, you say that...but people realize the reality. A person can choose to A or B or C. If you think not abstinence, then faithfulness, and if not, then you can use a condom. Young people will say that the church says this or that, but the reality is that you can make your own choice.

Despite the contradictory messages about condoms, which are likely contributing to the uncertainties about the efficacy of the devices among young people, it is believed that young people are capable of seeing through the diverse discourses towards a more secular “reality” of HIV prevention, one which in fact may be very different from that envisioned by HIV prevention experts. Thus, before meaningful communication can occur, a recognition and acknowledgement of the diverse viewpoints about safer sex must precede it, one that does not discount them outright as a form of misinformation.

What remains unacknowledged in the public health materials and public position on safe sex is an admission that condoms do fail, and that they may not be as effective as the scientific literature suggests, especially given the specifics of place, economy, and use in Namibia. Rather than promoting condoms as highly effective devices that seem almost resistant to failure, HIV prevention experts might do better to offer more candid dialogues on condom failure, thereby creating an environment of openness and an admission that people may have reasons to exercise caution when using condoms, without shifting directly into abstinence-only programs, which seem to also discount the realities and desires of many individuals. HIV prevention experts or may also do well to outline what individuals can do to avoid condom breakage, as well as what resources they can tap into if breakage does happen.

To address the anxieties of young people, I would venture that a more human approach to public health is necessary, one that recognizes the unique challenges and fears that individuals face when confronted with a seemingly senseless epidemic of HIV infection. Information can be helpful in allowing individuals to better make sense of the biomedical aspects of the illness, but cannot necessarily address the more intimate and emotional issues people face. While criticisms of didactic knowledge and information-based approaches to disease prevention are abundant (Bloom and Novelli, 1981; Farmer, 2001; McKenzie-Mohr, 2000; Yoder, 1997), less apparent are examples of novel approaches that take some of the factors outlined in this thesis into account. One notable example is the work of Brazilian educator Pablo Freire, whose theories on empowering education have been successfully applied to programs in diverse areas, including health promotion (Wallerstein, 1988; Minkler, 1980). Freire's central premise is that education is not neutral, but takes place in the context of people's lives. Thus, Freire advocates a dialogic approach that aims to empower participants by motivating them to "uncover root causes of their place in society – the socioeconomic, political, cultural, and historical context of personal lives" (Wallerstein 1988:382). Through this process, participants are encouraged to think critically, moving "towards the actions that people take to move beyond powerlessness and gain control over their lives" (ibid). While such an approach is undoubtedly more complicated than the usual expert-driven approaches, this one seeks to involve participants fully in the process of learning, rather than viewing them simply as passive targets of behaviour change and knowledge acquisition.

Another step in the right direction would be the facilitation of environments which empower individuals and allow them to maintain good health. I would argue that

funding for HIV prevention would be better directed towards initiatives that focus upon creating the environments that would allow young people to hold either abstinence, faithfulness, or condom use as realistic choices. For example, the development of income-generating projects that would allow young people to rely less on sexual relationships for financial support, as well as providing them with useful, and ideally meaningful, activities during their free time. Community development projects that offer young people activities or skills development would also be valuable, in that they would provide social spaces for young people outside of *shebeens*, which predominantly fill this role in the townships. Engaging in activities and skills development also builds self esteem, one essential component to effective decision-making in all realms. Also, community safety initiatives that would address the high incidence of rape in the country would assist those for whom engaging in unsafe sex is not a choice to be made, but is rather a condition imposed upon them. These are just three examples of how such environments can be facilitated; undoubtedly there are many more.

What may be most immediately helpful, however, would be an acknowledgement of the abusive history of population control that has occurred in Namibia, and of the remnants of this history that likely persists within the public consciousness. Discussions of such events do not occur within public discourse; likewise, the literature relating this history is absent from the National Archives in Windhoek, as well as the city's libraries. As such, it can be presumed that foreign and even local HIV prevention experts are either largely ignorant of this history, or have chosen to purposely ignore it in the development and implementation of their campaigns. Whatever the reason, it is obvious that both trust in public health and family planning campaigns and the effective management of rumours

or alternative health discourses are integral components in the successful implementation of HIV prevention programs. While it seems as though HIV prevention experts in Namibia are silent on this issue, it is by no means a silence particular to this region. The multiple literature searches I conducted on trust, health interventions and rumour as they relate to public health theories and policies turned up empty. Apparently such issues are not viewed as entirely relevant from the perspective of the public health apparatus.

HIV prevention experts acknowledge that the prevalence of the disease is not decreasing significantly, despite the fact that young Namibians possess a level of knowledge of 94% or higher about HIV and prevention methods (Witte et al 2003:24). What is needed is a move beyond mere acknowledgement of this fact, and toward innovative and holistic strategies that recognize the importance of historical and contemporary social contexts in influencing health-seeking behaviours.

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